Research – the ministers’ views

Iran’s women investigate health priorities

Volunteer women researchers are determining Iran’s health and development needs

Hossein Malekafzali, Deputy for Research and Technology, Ministry of Health and Medical Education, Iran, explains how community volunteers – who are mostly women – are helping with Iran’s health research and decision-making. Other countries should do it, he says.

RHN: Tell us about use of the community to do research in Iran. It’s striking that you believe that ordinary people can do research, but I understand that you’ve found in practice that they can – and that their work is useful to address some kinds of health problems.

Hossein Malekafzali: You know that one of the important issues in health is community participation. That has three levels. The first is for the community to give, for example, money for some activity, such as building a health centre. The second is that they can be involved in service delivery – for example in Iran we have women working as health volunteers, delivering health services to the people. But the third and highest part of community participation is when the community is involved in decision-making. So I was considering how I could establish that highest level of participation, in practice. continued on page 2

Summary

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Fortunately in Iran the community is highly educated. After the revolution the literacy rate, especially among women, increased tremendously – because before the revolution, there was no chance for women to go to university. But after the revolution, because the culture of the family and the culture of the universities became the same. So nowadays most of the girls have the chance to study.

RHN: So women’s rights improved after the revolution?

HM: Women’s rights to education improved.

RHN: That's quite to opposite of what happened in Afghanistan, for example, under the Taliban.

HM: In Iran before the revolution there was a virtual barrier for women to go to university, related to the culture, the environment, of the universities. It was a Western culture, not adjusted to what families expected of their girls. But after the revolution, the university environment became Islamic – so it matched family expectations. So now families send their girls to the universities.

RHN: But this is counter-intuitive, if you compare with another Islamic interpretation of education, under the Taliban, which was totally against education for women...

HM: Yes, but that was a misinterpretation of Islam. Because Islam says that everyone should be educated. But the interpretation of Islam is different in different countries! In my country, we say that “if science is in China, go to China” – this is from the Prophet Mohamed – because at that time China seemed a very very long way from Saudi Arabia. But he said you must go to China to be trained in science! And the emphasis is on training of both men and women.

So in Iran during this 25 years the education rate, especially among women, has increased. You know at this moment that among students in universities in Iran there are more women than men. For example in medical schools in Iran, 70% are women, and only 30% men! It’s a big problem, because when they’ve graduated the girls want to stay in the big cities and not go to the rural areas.

But to get back to community participation – due to this increase of education in the community, especially the women, three years ago I began actually to involve the people in decision-making.

RHN: What kind of decisions were you hoping for?

HM: The philosophy behind this is that the people are the most important ones to decide their own needs. If we have an educated population, we can empower that population to do needs-assessment, by themselves – and to identify their needs, not only health needs, development needs too. Based on some criteria they can come to some priorities. And then they will tell us how we can intervene for solving these problems.

Further, they themselves can evaluate what we have done! This is the involvement of the community in research.

RHN: So this is more than good democracy.

HM: It is democracy. We divide a region of 50,000 people in 100 clusters of 500. On a democratic basis each cluster is free to select one man and one woman (with at least a high school diploma) from each 500 who volunteer to be trained for research.

Actually most of them – perhaps 90% – turn out to be women. In my country, women are more interested in participating in volunteer activities. And that’s good, because most health problems, especially inside the family, are in the care of the women.

And these women are empowered to go to the various sectors, to talk to people and discuss the development of the local area.

So first of all we organize the community, and then accept two people from each cluster; and then train them for qualitative and quantitative research! It’s very very simple methodology. We have specific books to guide them. And with these books we explain what the problem might be, how they can analyse the problem, how they can collect information, and summarise it.

RHN: Can you give me an example of a problem that they might study?

HM: For example, people go to their neighbours with a small questionnaire, and ask them what their problems are.

RHN: What kind of problems do they ask about?

HM: General ones. Not just health. They do focus group discussions. They collect people, young, old, everyone.

RHN: So this is not just the Ministry of Health’s programme.
HM: The Ministry of Health was the pioneer! But now the other sectors are also coming in. Now we have the Ministry of Education, the local Mayor and so on.

So the representative of the people will go to that cluster, speak with the people, ask them questions, discuss and collect information. And based on that they analyse the data and come to some priorities.

For example the first priority might turn out to be unemployment. The second might be addiction. Then third might be environmental health. The fourth might be safety – violence. And so on.

So we get a list of priorities. And the point is that these priorities have come from needs assessment and priority setting by the people themselves. It’s not coming from the universities, choosing a topic of research. The subject of research is coming from the community. That is the difference, between traditional research and this.

>RHN: The concept is very radical. But can you give me an example of how this has worked for health?

HM: For example, in one area they said the first priority was garbage collection, from the houses and the streets. They said the streets were unsanitary, and the mayor doesn’t care. So they sat together, the community and the mayor, and they came to a solution – that the people have to do this and this, and bag their garbage at a specific time and place it outside their doorways, and the mayor would arrange collection.

>RHN: So the community not only does research, but ends up taking action.

HM: Yes – that was action research.

>RHN: What about its relevance, for example, to non-communicable diseases, which require behaviour change?

HM: Take cardio-vascular diseases, where the people need to take exercise, and change their eating habits, or stop smoking, or reduce stress... There the people sat together and organized how they can for example begin public sport, every Friday – when we don’t work. The women decided to collect together and go to the mountains for sport.

Or take nutrition. They went to shopping centres and tried to persuade shopkeepers not to sell oils that are harmful to the heart, or cigarettes and so on. So they changed the enabling environment for health.

"It's not coming from the universities, choosing a topic of research.
The subject of research is coming from the community."

HOSSEIN MALEKAFZALI

>RHN: So the way it works is this: there has been some academic research which has shown that this or that oil is dangerous for the heart; and in the community women’s research those results are engaged with community action, to create a practical change in behaviour.

HM: Exactly. This is operational research, it’s not to find the risk factors.

>RHN: But it seems to me it also creates their ownership of the solution; instead of being told what to do, they learn what to do themselves.

HM: We don’t expect to discover the impact of cigars, say – we know that from the literature. We want to know how to stop smoking, based on our own culture, because the way people are going to stop smoking is different in every country.

>RHN: Do you think this is a technique that other countries could adopt?

HM: Sure, sure! I’ll give you another example. One of the biggest issues is adolescent health. The girls and the boys, when they are adolescent, don’t communicate with their parents. And there is no chance to speak with them in the schools – there is nothing in the curriculum. So they are trained by their friends! And sometimes by satellite TV! This is dangerous.

So we started a pilot project, and we talked to the parents. We said this is your son or your daughter, and if you want to keep him or her, you have to communicate! And gradually it started. We trained the parents about adolescence. And the parents talked to the girls and boys. And the result is that the families are happier!

>RHN: That’s fundamental – if you managed to change the relationship between parents and adolescents – that’s almost a biological challenge...

HM: Well this is one of the studies we did in Iran. It worked because it is an Islamic principle, that it is the duty of parents to train and educate their children.

>RHN: I believe that in the matter of family planning, you took a quite sophisticated approach to discussing the issue with religious leaders, by being extremely sensitive to their constraints and views. It seems to me that that principle is generalizable – instead of researchers telling government what to do, we ought to be listening to government and understanding their constraints and needs more. Can you expand on that a little?

HM: The point was that the religious leaders who govern the community, based on Islamic principles, said that we must increase the population of the Moslem countries. That was the concept. So for ten years they encouraged people to have more children. But at the Ministry of Health we were worried about the consequences.

So we thought carefully what we had to do. And we went to the principles of Islam; and we understood that in Islam the protection of the body is more important than everything. So based on this principle... if I put my finger on the health of the mother and child, they would listen. Because it is an Islamic principle to protect them.

So I collected the health information and made a graph which showed that for

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example having a short gap between children increased the mortality rate of mother and child, the effects of early pregnancy and late pregnancy, so when they saw that this increased the mortality rates they said OK, we can’t say no!

And that was very important, because later the International Conference on Population and Development put family planning in the package of health, with mother and child health care.

So they accepted family planning for health promotion – not for population control. That's the point.

>RHN: That’s a very interesting story. And I think it’s true in general, that if you want a health minister, for example, to take an interest in some research that you’ve done, that you think is relevant to health improvement in the country, you also need to think about what are the minister’s problems, what context is he working in.

HM: The important point is that when we talk to policy-makers, we have to know to what aspect of policy they are most sensitive. And we have to collect the data that’s relevant to that aspect. That’s the point.

Hossein Malekafzali was speaking to Robert Walgate at the High-Level Ministerial Meeting on Health Research, Accra, 15-17 June 2006.

Research – the ministers’ views

Human existence “threatened by neglect”

Research by developing countries vital, says minister

> by Courage Quashigah, Minister of Health, Ghana

At the High-Level Ministerial Meeting on health research in Accra this June, the Minister of Health, Ghana, argued that major issues of vital importance to health in Africa and the developing world, such as local ideas and practices, the cultural effectiveness of the ABC strategy for HIV/AIDS, and traditional medicine, were being under-researched – because low and middle-income countries have too few research resources, and are not driving the international research agenda. “Our very existence” is threatened by this neglect, he said. This is a transcript of the minister’s address.

Over the last 50 years achievements in science and technology have been phenomenal. We continue to push the frontiers of outer and inner space, and in the effort we have unearthed many discoveries that have increased our knowledge of the environment, ourselves, and the relationship between the two. We have propounded several theories of why diseases occur, and how to treat and avoid them. Indeed we have the answers to many if not most of our health problems. Consequently life expectancy has gone up by 20 years in many low-income countries, and on the average infant mortality has fallen by about half.

We have eradicated smallpox, and are on the verge of eradicating polio. The global population has increased nearly two-fold in the same period. These developments can be attributed to the intensive research and development activities in the health sector, which has led to the previously unimaginable discovery of a large arsenal of drugs and technologies; and to our ability to process large volumes of information in the decision-making process.

But the paradox is that we also live in an era where the foundations of these gains are being threatened by factors both within and outside the health area. We are at a time in the history of mankind where our very existence is being threatened not only by diseases, but also by our own neglect of the knowledge we have accumulated over the years, and our basic social and cultural norms.

The HIV/AIDS pandemic; the resurgence of TB; the per-
"The long and short of it is that we do not have clear knowledge of the economic burden of the diseases that we are handling. This is an area for intense research."

COURAGE QUASHIGAH

sistence of malaria; and other debilitating diseases such as guinea worm, present us with challenges, which can only be met by recognizing that socio-economic and cultural factors are prime determinants of health and health care.

Unfortunately, as scientists we have placed and continue to place significant emphasis on finding laboratory solutions to our health problems expecting – or rather, hoping – that the social systems will adapt.

There is an increasing need for us as health policy formulators to recognize that people’s ideas and practices concerning health and illness, as well as social and cultural conditions leading to illness, are critical in the design of interventions.

We need to understand how diseases that afflict us originate in the context of people’s living conditions and lifestyles. We also need to understand how health problems are communicated in ways that are culturally prescribed, and how they are labelled in accordance with existing cultural concepts and belief systems. Natural scientists can only tell us what happens [physically]. But delivering effective interventions requires much more.

Although this meeting is about health research, the outcome is about how we can formulate effective policies that will reduce the disease burden in developing countries.

To do this, health research must increasingly have social and ethnocultural outlook. Indeed health research must focus more on health promotion, prevention of diseases, and protection from injuries, by concentrating more on the adaptation of cultural norms in the fight against diseases.

If children are still dying of malaria, mothers are dying in childbirth, and for 25 years HIV/AIDS is showing no sign of burning itself out, we in developing countries must definitely rethink our health policies.

This can only be done if we find the right balance between research and the design of appropriate interventions, and how the majority of us live.

Also, most of us recognize the link between ill health, poverty and underdevelopment.

Indeed in our parts of the world, being poor, female, and adolescent are risk factors for a myriad of health problems ranging from sexually transmitted infections to substance abuse. In many instances these vulnerable groups [are the ones with] less knowledge, fewer resources, and less power to defend or protect themselves, yet many of our research activities are not tailored to answer these questions.

Further, we need to break the vicious circle of underestimation of the value of research for development, the worsening or shortage of resources for research, and the persistence of problems of endemic diseases.

It is no longer sufficient to talk about building research capacity and research infrastructure without examining ways of ensuring sustainable funding and significant investment in bridging the gap between research and policy.

It is also important that the issue of coordination, ownership, and relevance begin to take centre stage in our deliberations. In other words we need to have our own independent means of validating the research findings published by the international community, and influencing their focus to address local health concerns as well.

Promotion of research in traditional and alternative medicine is also indispensable, and above all has the potential to provide practical,
efficient and low-cost solutions to many endemic diseases.

Unfortunately this is an area that most developing countries have left underdeveloped, and remains shrouded in mysticism.

The best legacy we can leave our children is to start a radical revival of this branch of medicine. With an infusion of scientific knowledge accumulated over the years, why have indigenous techniques practised over many years been left dormant?

Some of us believe that our lack of understanding of traditional and alternative medicine in our parts of the world arises from the limited investments in this direction.

There are many health challenges before us. We need to be broad-minded in our approach, and diversify our interventions. Our success in research and development of traditional medicine will probably be the best contribution that the health sector can make to the economic development of the developing world.

Apart from diseases afflicting individuals and populations, we also have deficiencies in health systems which receive little or no attention from international and local research institutions. These areas include infection control in our health facilities; integration of health information systems; and improving efficiency in the use of resources available in the public and private health sectors. This underscores the need for us to focus on research that improves the functioning of the health system as a whole.

Yet let me be quick to add that there have been some very good initiatives in this direction. Ghana’s Community-Based Health Planning and Services Initiative, which is now a major strategy for improving access to basic health services, was a result of one such piece of research. There may be many more; but the fact remains that judging from the magnitude of the problem this is still under-resourced.

We also need to demonstrate the results of our actions on the burden of disease. How much does it cost us developing countries to manage diseases such as malaria and other endemic health problems? The fact is that we talk about estimates, and indeed estimates made outside the actual environment where the diseases are experienced.

The long and short of it is that we do not have clear knowledge of the economic burden of the diseases that we are handling. This is an area for intense research – in the short term to make an analysis, as we developing countries review our policies towards disease management, prevention and health promotion. We must do this on a cost-benefit basis.

It is only after engaging in such an exercise that we can see more clearly the correlation between health and wealth creation. Such research should point on the one hand at the savings to be made from the reduction in treating and preventing avoidable diseases; and on the other hand at the wealth to be created from the high productivity of a healthier population.

We also have to reorganize ourselves to ensure that the right focus is achieved in the international research area. It is not enough to accept research results, conclusions and recommendations done on our behalf. What we must realise is that some of such conclusions and recommendations are not based on real local scenarios. That is to say that many of the confounding factors within our local environments are usually not taken into consideration.

Let me give an example. The HIV/AIDS pandemic is being fought through the ABC campaign – abstinence, faithfulness to one’s partner, and condom use. As we speak, there is no substantive evidence that this strategy has led to behavioural change. Yet we have not done any research into why this is so.

There are some countries that claim that condom use has gone up. My question is – was this statistics from the shops, about how many condoms have been bought? Or is somebody going round collecting used condoms? Or is somebody physically witnessing the use of condoms?

Perhaps the low acceptance of condom use may have its roots in our social and cultural values, which may be addressed by fashioning localised strategies based on those values. That is the only way we can develop and implement effective interventions.

If we are to move from our present socio-economic status as developing countries, we should seriously work on improving the health of our people, and we can only do that if we place a high premium on research – which is the core of knowledge. But we must articulate the challenge clearly, and ensure that it can be owned by all.

Courage Quashigah.
Burkina gives science a warm embrace

Research is an aid not only to good health policies – but even to political success, say ministers

**Research – the ministers’ views**

"There’s complete synergy between research and our health policy-making... we couldn’t act effectively against disease today without research!"

**SUMMARY**

In a interview with *RealHealth-News* and Burkina TV (RTB) during the annual general and scientific meeting of INDEPTH, the international network of focal demographic surveillance sites, Burkina Faso’s ministers of research and of health revealed that they are impressed by the power and potential of science to solve problems – even when its results are politically sensitive.

**RHN**: I understand that research means a lot to health in Burkina. Can you give me an example where research has changed Burkina’s health policy?

**JOSEPH PARÉ**, Burkina Faso’s Minister of Secondary and Higher Education and Research: Well take onchocerciasis for example. We’ve controlled it in various regions only because of the techniques that research has taught us, showing us precisely the most effective actions that health workers can take, in the field. There are very many examples.

**RHN**: INDDEPTH research can be extremely political – because its demographic and health studies reveal inequalities. Is it possible to convert their results into a political action and policy?

**JP**: Absolutely. Burkina Faso has a government that acts on these things, working in synergy with our development programme – there’s complete synergy between research and our health policy-making. Our overall politics calls on us to struggle against poverty, to improve the living conditions of the population and to make the products they need for their health available at an affordable cost.

**RHN**: Minister of Health, does research in general study the things you need? If you were free to ask for what research you liked, what would it be on?

**BEDOUMA ALAIN YODA**, Burkina Faso’s Minister of Health: My colleague has explained clearly that health, research and politics are one package together. We just could not prepare good health policies without research. In fact we couldn’t even prepare good development policies at all without research.

That’s to say that the research INDEPTH fits in perfectly with our health politics. In fact it’s very important for politics in the general sense, because it’s an aid to making decisions that will have good results!

**BJÉRÉMI SIÉ KOULIBAL Y**, for RTB (Burkina TV news): Minister, what is the interest of this INDEPTH health research meeting for Burkina?

**BEDOUMA ALAIN YODA**: It has enormous interest! In the sense that we couldn’t act effectively against disease today without research! There are new diseases rising in importance in Burkina; and there are old ones that happily we’ve eliminated. Our four health research centres do both fundamental and applied research. Their results are very useful, because they help us to adapt our health policies [to this changing world].

Take malaria for example. The old treatments are no longer effective. Research demonstrated this – and developed new much more effective treatments, in coordination of course with WHO and other development partners.

INDDEPTH is a network of over 40 centers in many countries, represented at this meeting, to exchange their experience, comparing results in one country with those in another, looking for means to improve the health of their people. Research has no nationality. It’s global.

**RHN**: *RealHealth-News* interviewed Joseph Paré and Bedouma Alain Yoda while attending the annual general and scientific meeting of the INDEPTH demographic surveillance network in Ouagadougou, courtesy of support by EAGLES, the European Action on Global Life Sciences.

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Research - the ministers' views

Science beats ideology

Julio Frenk says science can help face special interests

The scientific rationality of the massive study, Disease Control Priorities in Developing Countries (DCP2), and its claim that achieving better health is a “technical” and not a political matter, may just cut through the tangle of interests and politics that holds back better health for the poorest. Julio Frenk, Mexico’s health minister, thinks so. He says science can help challenge special interests and ideologies.

RHN: DCP2 is a supremely rational exercise, and it has produced a massive set of documents and guidelines. Arguably these are the most rational and complete documents on how to improve global health that we’ve yet seen.

But how do you move from the rational to the political? Because the world is not rational – it’s a political world. At the World Health Assembly 2006, for example, we heard a heated debate on the best way to manage global R&D for health, with polarised positions being taken, for example, on intellectual property rights. There was an agreement, but only for more debate. So how will the solutions presented in DCP2 turn into political fact?

JULIO FRENK: How much time do we have? I always like to think that public policy is supported by three pillars. There is of course a technical pillar, and we have to be very careful about it and do our very best [to strengthen it]. These are the knowledge-related global public goods, like DCP2; like the WHO-CHOICE [choosing interventions that are cost-effective] project; like the international classification of disease; like our ability to count how many people die of what.

All of those and many others are public knowledge; and they are also what WHO is all about, bringing the collective action of sovereign nation states to generate these elements that benefit us all – with due attention to the inequalities in the world. So that’s the technical pillar.

And then there’s an ethical pillar, and we have to be very explicit about that. Every policy that we apply has a value component. Priority setting should be based on cost-effectiveness – and social and ethical acceptability.

And the third pillar is a political pillar – in the good sense of the word. Because “politics” is a word that has sometimes been stained – and sometimes with good reason. The good sense of the word is the capacity to achieve agreement around shared objectives. In this sense you always need a political pillar.

I would contend that the political realities are not irrational. They have their own rationality, which we need to understand. And I would contend that good evidence can feed into a better political process.

The three pillars interact as they do in any building.

By the way I’m drawing this idea of the three pillars from the work of my colleague Michael Ryan at WHO [Director of the Department of Epidemic and Pandemic Alert and Response], but I’ve had a chance now to apply it in reality.

I’ll give you one specific example, in Mexico. Some very technical work in national health accounting revealed that we were spending three times more per capita on people who were salaried workers in the formal sector of the economy, and who already had social insurance – than on unsalaried peasants and people in the informal sector of the economy. Three times
more. No one had measured that before. And it was very serious technical work – no one could challenge it.

So we went to Congress. And we asked “do you believe that the life of an urban salaried worker is worth three times more than that of a peasant?” They said no – all human lives are worth the same.

So then we said: but you are revealing, with your spending, a set of values that contradicts what you are telling us!

That was a very valuable moment, with a political effect, to move to the political pillar. So Congress accepted health insurance, and improved the budget of the Ministry of Health – which by the way has doubled during the six years that I have been minister, because of this kind of reasoning.

But then we came back and said we are not asking for a blank cheque – we are going to do this and this and this, and this is our reasoning. We used the WHO-CHOICE project and the first edition of DCP, and we said this is exactly what we are going to get you. And we were able to assure them that we were going to get not only more money for health, but also more health for that money.

So the three pillars work together. Probably what you are referring to as “political” I would rather describe as “ideological”. And there I would agree with you. We need to replace ideology with free thought and conceptions, so people face the power of real good evidence; and then we must feed a more open and ethically driven debate to achieve good political work, in the sense of achieving agreement on shared societal goals.

> RHN: The politics I’m thinking of is not only ideological – there are also interest groups [who profit from one situation rather than another], and their ideology usually fits their interests... so you have to negotiate with these interests and powers. The rationality of DCP2 addresses only one half of the problem...

JF: Absolutely. But a good analysis can actually empower a decision maker to face up to special interests. Of course if the decision maker is himself or herself part of those interests that’s a different story! But if you are not... We see this every day. All the doctors want to buy the latest machines or drugs or whatever. But if you have good cost-effectiveness studies you can explain that this may not be the best investment that you can make, and I can convince you or persuade you. This can actually empower you to face some of those interests.

In default of a good technical analysis, you may take the wrong decision and not even know it. And you may succumb more easily to special interests.

> RH N: You rely on the minister being both rational and ethical, and focused on getting the best health for his or her people. But that’s not always the case. For example there’s corruption...

JF: Sure, the reality has all those other components.

> RHN: ...and there’s pressure from the pharmaceutical industry and medical suppliers, there are substandard and counterfeit drugs, and so on, and I wasn’t sure that DCP2 was facing up to all those other issues.

JF: Well DCP2 is a project on the technical issues. As you move into the countries you need to take into account all this... but you know having this tool will not make all those other forces worse! If anything it will improve the situation.

> Julio Frenk, Minister of Health, Mexico, was speaking to Robert Walgate at the World Health Assembly, Geneva, 2006
Research - the view from WHO

What’s WHO doing about research?

WHO now has research “right at the centre” of its mandate

SUMMARY

At the High-Level Ministerial Meeting, Accra, Tikki Pang, Director of WHO’s Department of Research Policy and Cooperation, argued that WHO is now in a uniquely strong position to address key issues such as public trust in clinical trials, encouraging policy-makers to respond to evidence, and promoting local health system research. This is a report of his address.

At the WHA 2006 a very important document was presented – the 11th General Programme of Work, which describes WHO’s plan of action, a strategy, for the next 10 years. And within that GPW, WHO’s core functions were identified. “Research has been placed right at the centre” of those functions “giving us a crucial mandate” said Pang.

As a consequence of these core functions WHO is enjoined to “shape the research agenda”, “set norms and standards and promoting and monitoring their implementation”, and “articulate ethical and evidenced-based policy options”.

The Advisory Committee on Health Research, established in 1959, with its six regional committees, is WHO’s tool for shaping research agendas, Pang said. And WHO is playing an immediate role in setting norms and standards in the case of clinical trials.

It is essential to increase public trust in such trials, he said – but recent events and media attention are shaking that trust.

“Many of you know of the recent debacle in the UK [Northwick Park, Harrow, Middlesex] where six patients given an experimental drug became very very ill. This I think reflects an overall problem with the way the pharmaceutical industry is conducting clinical trials, and sometimes withholding information” Pang said.

Also “trials that give positive results are published much faster than trials that give negative results... “So there’s an issue about transparency, accountability, and access to the results of clinical trials.” Simultaneously, “many many more of these clinical trials are going to go into the developing countries...”.

So WHO is launching an International Clinical Trials Registry Platform, to link the increasing number of separate national and other trials registers. The platform will aim to make every single trial searchable through a WHO portal.

“The goal is to strengthen public trust, promote transparency and accountability, to ensure that all trials are registered, declared and identifiable – and that a minimum set of results is publicly reported for all trials. We’ve defined a minimum data set of about 20 items” said Pang.

Trial registration is also of enormous importance to national health systems, he said. “They have an impact on health system planning. I heard for example of a recent HIV/AIDS vaccine trial in Malawi, which employed 70 nurses – and I believe Malawi doesn’t produce even that number of nurses in a year!”.

“There is clearly a huge concern about the ethics of doing research in health in developing countries” said Pang, and this is also falls within WHO’s core functions. “WHO is very very strongly championing the ethical conduct of research” he said. For example, “TDR has a programme focusing on developing capacity in developing countries for ethical review of research, and developing guidelines on how to establish national ethics committees”.

WHO also promotes evidence-based policy making. An example is the Framework Convention on Tobacco Control. “We know very well the advertising power of tobacco industry, and that that power is now focused on developing countries, promoting cigarette smoking even amongst adolescents. But the Framework Convention used scientific evidence to produce the first ever global health treaty – which is legally binding in all the 131 countries that have so far ratified it by the time of this meeting [June 2006]”.

WHO is also promoting Evidence-Informed Policy Networks (EVIPNets) “to develop in-country mechanisms and structures” to strengthen research-to-policy linkages. “We launched this in WHO-WestPACRO in 2005 with Laos, Malaysia, the Philippines, Vietnam and China, and in WHO-AFRO in 2006 with Burkina Faso, Niger, the Central African Republic, Ethiopia, Zambia, Malawi, Angola, Cameroon and Mozambique.”

At the end of 2006 there’s to be an international dialogue, in Thailand, where we will put the policy-makers on centre stage and ask them “what are your needs”, as far as evidence is concerned. And in addition to the policy-makers we will have citizens, NGOs and civil society groups involved in the dialogue, with the researchers taking very much a background role. The aim is to have “a very frank and open dialogue about how evidence can inform policy”.

WHO has also established a Health Evidence Network, based in WHO-Euro.
It responds to policy-makers’ questions: “it’s not driven by researchers…. Evidence is synthesised, a ten-page report is prepared and a one-page summary with policy-options”.

“WHO’s added value comes because we are seen as independent, neutral and credible, we have technical competence, political legitimacy as a result of being owned by our member states, and convening power” said Pang, “…and the ability to take on neglected and sensitive areas” like tobacco and clinical trials. “And then we set standards, and have a global reach to all countries.”

TEHIP – the Tanzania Essential Interventions Project, where research evidence strengthens health systems, is a clear example of the benefit of research to developing countries, said Pang. “This is community-based participatory research, to determine the true causes of death in two districts of Tanzania, where 40% of the deaths occur in homes”.

“As a result of [those studies] the district health budget was adjusted to reflect better what was actually going on – and from 1997 to 2003 – the duration of TEHIP – they saw a 52% reduction in under-five mortality…. As a result, Tanzania is well on the way to reaching their MDG target long before 2015.”

“The challenge of course is to make sure that this kind of knowledge is used locally” said Pang. Weaknesses in health systems are central, and key research questions include:

- How can we develop sustainable health financing and care for the needs of the poor?
- How to create one million health workers for Africa in the next ten years?
- How do we ensure access to safe, effective and cheap interventions?
- How do we develop a sustainable and reliable health information system?
- How do we integrate vertical programmes into the broader health system?

But to do this research, government commitment is very very important – and that’s the reason for the WHA resolution that countries should spend 2% of their health budgets on research. To governments that are reluctant to do this, I would just like to say if you think research is expensive, try disease.”  RW ■

WHO’s Department of Research, Policy and Cooperation
www.who.int/entity/rpc/en

High-Level Ministerial Meeting on Health Research, Accra, 15-17 June 2006:
www.hlresearchdev.org/

UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)
www.who.int/tdr/index.html

UNDP-UNFPA-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)
www.who.int/reproductive-health/hrp/

Council on Health Research for Development (COHRED)
http://cohred.org/cohred/Home.action

Global Forum for Health Research
www.globalforumhealth.org

International Conference of Health Research for Development, Bangkok, 2000
www.conference2000.ch/index.html

Genetics, genomics, and the patenting of DNA: review of potential implications for health in developing countries
www.who.int/genomics/patentingDNA/en/

Macroeconomics and health
www.who.int/macrohealth/en/

DCP2
www.dcp2.org

Mexico Ministerial Summit on Health Research 2004
www.who.int/rpc/summit/en/index4.html

WHO’s 11th General Programme of Work
www.who.int/gpw/en/

Advisory Committee on Health Research
www.who.int/rpc/advisory_committee/en/

Alliance for Health Policy and Systems Research
www.who.int/rpc/alliance/en/

Initiative for Vaccine Research (IVR)
www.who.int/vaccine_research/en/

Reproductive Health Library (RHL)
www.rhlibrary.org/

International Clinical Trials Registry Platform
www.who.int/icctrp/en/

ClinicalTrials.gov
www.clinicaltrials.gov

International Standardised Randomized Controlled Trial Number registry (ISRCTN)
http://isrctn.org

Framework Convention on Tobacco Control
www.who.int/tobacco/framework/en/

Evidence-Informed Policy Network: EVIPNet
www.who.int/rpc/evipnet/en/

Health Evidence Network
www.euro.who.int/HEN

Tanzania Essential Health Interventions Project (TEHIP)
www.idrc.ca/en/ev-3170-201-1-DO_TOPIC.html

Millennium Development Goals (MDG)
www.un.org/millenniumgoals/
Facing a critical period in its history, stakeholders are looking for some refocusing of TDR’s responsibilities. Ridley listed the classical targets of the organization: R&D and research capability strengthening in the South to produce and evaluate new tools for tropical diseases – a key cluster of major and neglected parasitic diseases such as malaria and trypanosomiasis, and more recently – dengue. He also claimed TDR’s growing expertise and experience in diagnostics (such as for sexually transmitted diseases), in “implementation research, to inform scale-up of interventions, such as anti-retrovirals” and “knowledge management and research prioritization”.

In the next several years, Ridley foresaw greater public awareness and increased funding for research; a growing number of new players and initiatives; a probable rise in relevant pharmaceutical products; more initiatives for control and elimination of diseases; and more research by disease endemic countries. But at the same time he warned of a persistent and significant disease burden “despite efforts”.

In response to this new world, and perhaps thus creating the strongest theme to emerge in Accra, Ridley stressed TDR’s sensitivity to Southern agenda-setting – and health ministers’ support for this concept [see for example our report of the address of Courage Quashigah, Minister of Health of Ghana, page 4].

Whereas under past leaders TDR felt it helpful to distance itself from governments, and in particular from WHO and its members, increasingly the Programme has been emphasising its government and WHO links at international, regional and national levels – because they are unique to the organization, and provide the immense added value of directly connecting TDR and its research with major global and national health policy-makers.

In this embrace, TDR argues, research is ready to listen to policy-makers’ needs; and policy-makers are ready to learn the results of research – the only means through which research has a chance of becoming practical action for health.

The challenge and opportunity in such a broadly connected and more political TDR will be to “manage interfaces” among TDR’s many partners, said Ridley, and to “look beyond single issues”, at crosscutting themes. RW ■

Ministers join hands on research

Fourteen Ministers of Health and Heads of Delegation from Africa, Asia, Middle East and South America, meeting in Accra this June, reached an historic agreement to link up, South-to-South, on health research – especially to discover and share measures to improve the working of their “fragile” health systems. The countries also stressed the need to improve their own research base, and better understand their own national burdens of disease – and committed themselves to invest at least 2% of their health budgets on research and research capability strengthening. ■

> The full five-page Communiqué (PDF) may be found at: http://tinyurl.co.uk/kfqy

TDR: we all belong to the South

SUMMARY

At the High Level Ministerial Meeting on Health Research in Accra this June, Rob Ridley, the Director of the Special Programme for Research and Training in Tropical Diseases (TDR), sponsored by UNICEF/UNDP/World Bank/WHO, said greater responsibility for research should be placed in the hands of the South – the disease-endemic countries – amidst the multitude of new global players in health research.
Research is not enough

Local communication, evaluation and civil society essential

Research has taught us many good lessons about what works and doesn’t work in health care for the poorest, said Lola Dare. But we need to heed those lessons.

“Take maternal mortality, which is high on the development agenda, because of its place in the Millennium Development Goals. Emergency obstetric care works. Community education works. And improving access to emergency obstetric care at first referral and first contact has helped in some countries to reduce maternal mortality.

“We also know what doesn’t work. Routine antenatal care doesn’t appear to work. Training of traditional birth attendants continues to be contentious in its impact on maternal mortality, and predicting complications needs continuous discussion.”

Everything we have learned we have learned by implementing research that is relevant to policy, relevant to disease priorities, and is also feasible within operational systems, said Dare.

“We’ve also learned that educating girls saves lives. The more educated we are the less our children are likely to die. We’ve learned that condom use among sex workers will prevent sexually transmitted infections: increasing condom use in Senegal correlated strongly with rapid decline from 1991-1996 in the prevalence of trichomoniasis, chlamydia, gonorrhoea, and syphilis. This lesson is not peculiar to Africa. We’ve learned the same from Thailand.

“We’ve learned from Sri Lanka that a reduction in maternal mortality from 500 to 600 per 100 000 live births in the 1950s to 60 per 100 000 is possible. The approach was an integrated and strengthened health system, increased training of health professionals, improved access to both basic and higher levels of services, and ensured availability of basic health supplies. With this approach maternal deaths were halved every 12 years.

“The lesson we take from this is that rapid progress can be achieved at low cost, but for that to happen the fundamental building blocks of health systems, health workers, and referral including supervisory support has to be in place.

“We know what to do, and we have the tools.

“For malaria, we have artemisinin combination therapies (ACTs) and insecticide treated bednets (ITNs). Research from Gambia and Tanzania shows that ITNs reduce infant mortality. We are also very confident that HIV/AIDS can be resolved with a combination of abstinence, behaviour and condoms, and effective use of antiretrovirals (ARVs) by those who are infected. For vaccine-preventable diseases we have the vaccines; and TB has DOTS.”

Yet health and health care among the poorest remains appalling, Dare said. “What we should ask ourselves is why is this so, in spite of knowing what works and what doesn’t? What are our challenges, and what are the gaps?”

The capacity to understand and to drive research needs to be improved in ministries of health, said Dare. “The research capacity of many developing countries remains weak, and many ministries of health have research units in name only” said Dare. “In fact the truth of research in many developing countries is that research is conducted by academic institutions, and is very poorly shared with public health institutions.”

“The way we communicate health research to policy-makers also needs to be reviewed. For much of our research, our publications end up in journals like The Lancet, and the British Medical Journal, and I’m not convinced that many ministers of health have read copies of these in quite a while – even ones very committed to health research, like the minister of my country Nigeria, Professor Eyitayo Lambo. Even such ministers are unable to use research publications to drive health policy.

“The communication of health research needs to look at alternative platforms for knowledge sharing, dialogues, and using other forms of local communication to share what we know.

“The translation of research into policy and practice is also a huge gap. The Alliance for Health Policy and Systems continued on page 14 >
Research is investing a lot of money in doing research that helps to translate into policy and practice. And there’s an interesting move in microbicides, with investment in research on the policy actions that will be required to ensure delivery of new products, as a part of R&D for creating the microbicides.”

Such policy research “should ensure that the products are operationally deliverable and that the policy environment is ready, even as the product is being created”.

“Another very important gap is impact evaluation. There is very little assessment of what works and does not work at national level. So scale-up becomes a challenge, and there is a need for us to increase impact evaluation so we can improve aid effectiveness, and so that as we scale up at national level we can scale up only what works – and not what is politically driven.

“What are our options for response to these challenges? There are many – some of which we are effectively harnessing and some of which we are not. There is a beacon alight on global health, and we in low and middle-income countries should not miss it. Just look at the investment in the Global Fund to fight HIV/AIDS, TB and malaria, in GAVI, in new initiatives at the global level establishing partnerships to address our needs.

“I’d like to draw attention to the Paris Declaration on Aid Effectiveness (2005) – which also created an environment to assist us to have a voice on the global agenda, and also to monitor our development partners for aid effectiveness. These are areas we can harness.

“We should also strengthen Southern leadership and collaboration. Personally one of the great attractions of this High Level Meeting process is the uniqueness of working from Africa with our Southern partners. We can learn a lot from them, and we can share a lot with them.

“In this regard we also need to look at regional collaboration. There is a lot of information within Africa that is not shared”. Improving the transition of research to action, and policy, promoting impact evaluation, and building our capacity to engage on a global agenda are essential said Dare.

“We continue to commend WHO for its investment in research. One thing that’s clear is WHO’s strategic advantage and placement across its many departments in moving forward research for development. WHO has invested significant amounts in capacity building and institutional strengthening. And we want more, not just in academic institutions but also within the public health service to assist them to contribute to the research agenda and make better use of the research that emerges.

“My Provost is sitting here, but I would like to challenge him: as he drives research in Nigeria, he should let the research be sensitive to policy!”

LOLA DARE

“While we continue to encourage African governments to spend 2% of the total health budget on research, we also need to examine the net level of the health budget, whether it approaches the target 15% of government budgets, and what they are spending it on... And we ask our governments to develop national strategic plans for health research that can provide the evidence base to guide national health policy and systems action.

“Also, very little of the resources spent by the global health initiatives and partnerships is spent on research. Our governments should also encourage those global sources to spend a fair proportion of their funds on research.

“We ask WHO to join with us and ask other development partners to look at their programme budgets and devote at least 5% to research; and to improve the global coordination of health research. At country level, we have many research processes coming in, from all of the global partners; there needs to be some global coordinating mechanism that would allow our public sector officials to make better use of the information that is generated.

“There is also a need for governments to monitor research output by academic, research and other non-state agencies – particularly of the reports of many NGOs and community based organizations that contain valuable indigenous and tacit knowledge that can provide a resource to drive progress.

“Academic and research institutions also need to implement research programmes that are relevant to national and regional challenges. I am an academic, and my Provost is sitting here, but I would like to challenge him: as he drives research in Nigeria, he should let the research be sensitive to policy! Research that makes more professors and has very little impact on our capacity to improve our health system, and leaves our public sector on the shelf, can still be important; but it is also important to do research that is relevant to national policy and is able to respond to new challenges.

“We also need to develop platforms to communicate and share research findings. Research institutions in Africa are generating a lot of knowledge; a random Medline search shows that loads and loads of knowledge is being generated from research by Mexican researchers, for example, and from other Latin American centres, but there’s minimal sharing across continents.

“I want also to call attention to the Global Forum for Health Research. It is an important forum where we have a lot of people from both South and North coming to share research and ideas. There is a move to establish regional platforms for the Global Forum, and I think our governments should seize it, to use them as platforms to share knowledge.
“There is also a contribution by civil society organizations, which can be brokers of evidence for change and action. They can provide a neutral forum for consultation and dialogue; and they can broker evidence and relationships among strange bedfellows and interested partners! And they can advocate with governments for informed decisions.

“One thing that I’ve also learned is that when governments change, civil society organizations remain! If there is an issue that a civil society organization believes in, it will get the next government and the next and the next to continue on it, like that promise to provide ivermectin for as long as it was needed.

**READ ON**

High Level Ministerial Meeting on Health Research, Accra, 15-17 June 2006  
www.hlmresearchdev.org/  
African Council for Sustainable Health Development (ACOSHED)  
www.acoshed.net/  
The Alliance for Health Policy and Systems Research  
www.who.int/rpc/alliance/en/

**Research – the views of leading women**

**A passion for fungi – and research**

Cryptococcus led from fascination to research directorship

**SUMMARY**

Elizabeth Castañeda is a leading figure in Colombian and international research, working on opportunistic infections in AIDS, pneumonia and meningitis, identifying virulence factors and helping to develop vaccines. Not least, she has played a major role in opening up Colombian health research to the world.

> by Lisbeth Fog

Elizabeth Castañeda is a Colombian health scientist, research sub-director of the Instituto Nacional de Salud (INS-National Institute of Health), specializing in microbiology and mycology. She has focused on two microorganisms, a fungus and a bacterium, one critical in opportunistic infections in HIV/AIDS and on the other in pneumonia and meningitis. Her research has illuminated the science of these organisms, but also has empowered public health programs to treat patients. And she created a culture among Colombian scientists to publish their work.

She thinks that if she hadn’t been working at the INS, she wouldn’t have been able to accomplish her tasks... and fulfill her dreams. But she prefers not to talk about the role of women in Colombian science – “It’s not an issue here!” she says. In modern Colombia, if a woman or a man is good, he or she can become whatever they want. Research salaries, for example, are determined by training and publications, no matter the gender. “It’s just difficult to be a researcher in Colombia, because it is a different style of life” says Castañeda.

> RHN: Why did you focus your studies on a specific fungus?

Elizabeth Castañeda: Fungi attracted my attention because of their capacity to produce illness in humans, and the way they affect the human host. I started studying Cryptococcus neoformans from the immunological point of view when I was doing my master’s in Mexico, trying to understand its [polysaccharide] capsule, which is its main virulence factor. Then, when I got back to the INS, I set up the mycology laboratory, to study several fungi, but mainly this one. I have a friend who says that in studying Cryptococcus neoformans “I have submitted to my passion” and I know that he is totally right!

> RHN: Why was this fungus important in Colombia?

EC: Well I started studying C. neoformans before the HIV/AIDS pandemic. Then, most patients had susceptibility factors such as autoimmune diseases and there were relatively few cases - although mortality was high. But it was shocking to see that the cases increased astonishingly when the pandemic started.

> RHN: What was the relation?

EC: C. neoformans becomes an opportunistic fungus due to the lack of immune response of the AIDS patients. The patients had already been infected by the fungus, and apparently they had controlled the illness, but as soon as their immune response went down, continued on page 16 >
Cryptococcus became more visible and the number of cases went up very rapidly. In a way, cryptococcosis has become a marker for patients with AIDS.

The problem here is the treatment for HIV. When patients have access to antiretroviral therapy and can afford to receive the complete treatment, their immune system starts working again and therefore the opportunist infections decrease. In the USA, cryptococcosis is not a big deal anymore in AIDS patients, but the situation in Colombia is quite different.

But I would like to stress that not only have we found people with cryptococcosis who have no AIDS – for example in women treated with corticosteroids or patients who have gone through a transplant surgery – but also in people with an apparently normal immune response; the latter condition is still a mystery.

>RHN: Do you have any hypothesis for that?

EC: Yes. That it’s the [extreme] virulence of the particular C. neoformans that infects them. Our lab is studying this in animal models, along with other labs around the world.

>RHN: And I believe you found an environmental link.

EC: At the beginning we were focusing our study in the patients, but then we decided to study the environment in which the fungus prefers to live. We knew that in the USA, and all over the world, Cryptococcus was associated with pigeon excreta, and in Australia with eucalyptus trees. But were we speaking about the same species?

We studied the environments associated with C. neoformans in Colombia and found that one of the varieties of the fungus was associated with the almond tree, Terminalia catappa, a tree that came originally from India. This was reported for the first time in the scientific literature and has been confirmed in later studies.

[C. neoformans comes in several subtypes: for example subtype B is associated with eucalyptus trees. Castañeda and colleagues showed that subtype C - common among patients in Colombia – associates with almond trees. See reference below. – ed.]

>RHN: Are you still working on that?

EC: The interesting thing is that since the late nineties we have been invited to an international meeting on Cryptococcus and cryptococcosis that takes place every three years, to present the results of our research – and have become part of a huge study to find out the state of the art and the trends of cryptococcosis. This triggered our active participation in what I call ‘the cryptococcosis crusade’, a national survey that we started in 1997. By 2005 we had applied the survey to 900 patients, and now we have reliable data on this issue. Before this, everything was anecdotal. Now we know that 80 per cent of patients with cryptococcosis are co-infected with HIV.

>RHN: Let’s switch to your work on bacteria and pneumonias.

EC: This started ten years ago, when a representative of the Pan-American Health Organization (PAHO) proposed to the INS that we investigate what Streptococcus pneumoniae serotypes were affecting children under five in the country.

Haemophilus influenzae and Streptococcus pneumoniae are the causes of pneumonias and meningitis in young children throughout the world. A vaccine was developed to fight Haemophilus and was very successful. The cases fell, and now you can seldom find children infected with it.

But the vaccine to fight S. pneumoniae was designed for North American children, because they knew already the exact serotypes – seven in total – that were affecting them. So for South America PAHO wanted regional data. They had the feeling that the serotypes could be different.

We accepted the challenge and I led the research group, with the help of an exceptional core of researchers, funds from the Canadian government, and hospitals from the biggest three Colombian cities. We called the program SIRE-VA, which meant Regional System of
Vaccines from PAHO. It also included other countries, such as Brazil, Argentina, Chile, Uruguay and Mexico.

Again, the data available were scanty. With the help of a Canadian lab, which was our international reference lab, we reached high standards of quality control. One or two years later we found that two serotypes that were not included in the heptavalent vaccine, were really important for the region.

> RHN: What happened then?

EC: Colombia could have used the North American vaccine; however, to include it in the public health programs would have raised the cost more than one thousand times – because it is very expensive. And secondly, according to our studies, it would have been effective only in 75 per cent of our kids.

We are almost sure that thanks to our data we have demonstrated that it is important to include those two serotypes that circulate in Colombia in a new vaccine, and some pharmaceutical companies are working on that. This is very satisfactory.

> RHN: What about the other Latin-American countries?

EC: SIREVA is now working in 21 Latin American countries.

As the program expanded and Canada was unable to do everything, PAHO selected two reference labs in the region, one in Brazil and the other one in Colombia, here at INS. We are in charge of eleven of those countries (Mexico, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, Panama, Ecuador, Peru, Bolivia, and Trinidad and Tobago – which gathers in the English-speaking Caribbean Islands). We have grown a lot in knowledge and in practice on this issue and the world respects us for that. Brazil is in charge of Argentina, Chile, Uruguay, Paraguay, Venezuela, Dominican Republic and Cuba.

> RHN: Though you have been a key person in these ‘crusades’, as you call them, you have led many other projects. You are a leader at INS, and nationally well known and active.

EC: Sure, but if I had not been at INS, I would have not been able to accomplish all these things. Here you have a wonderful infrastructure, you can communicate easily with the public health labs located nationally, and can coordinate the programs.

Please remember also that I have spent my working life here. So I have passed through every post a researcher can fill, and now I am the Research Director. I created the weekly academic meetings, the publications committee, and have always been very active.

I am aware of my leadership but I have also been fortunate in finding very valuable people to accompany me. Sometimes it is a bit exhausting, I must confess… because I am very demanding and too disciplined, and those characteristics are very difficult to find in other people, and are not easily taught!

When we decided that our journal should be indexed internationally, for example, that was something special.

> RHN: Tell me more about it.

EC: Biomédica is 25 years old already but it became internationally indexed in 2002 – four years ago. Obtaining this recognition was like a dream come true. We worked hard to accomplish that goal – and to keep our indexation.

We started setting high standards for the articles, organizing the board of reviewing editors, and the senior editorial board; and we had to work a lot on the abstracts, in English and in Spanish, and so on. At the beginning we did all the work ourselves. And we started publishing the journal on time, which is a major issue! Nowadays more than 60 per cent of the articles come from outside the INS, almost all of them are from Colombian authors from different research groups, and we are publishing four issues per year.

We have learnt that the key issue is not to index the journal, but to maintain it with the highest standards.

Nowadays the first copy that comes off the press does not go to the INS Director; it goes straight to the National Library of Medicine.

> RHN: At this point, after so many years dealing with microorganisms, is there anything more that you’d like to study?

EC: When the avian flu cases started to appear, I thought that if I were 20 years younger I would dedicate my life to viruses. Virology seems a fascinating world. Remember the SARS episode? That was really exciting, to see how the information reached everyone in the scientific world, and the public, faster than ever. That was amazing.

> RHN: Yes. I remember you organized the first conference in Colombia to speak about it – and that was open to the public.

EC: Yes. Everyone should be kept up to date. It’s really important nowadays.
From the establishment of the New China in 1949 until the early 1980s, Chinese farmers enjoyed a form of cooperative healthcare system. However, with the rise of market economy in China, this old system gradually disintegrated, leaving 90% of Chinese poor farmers financially vulnerable to illness. Responding to this, trials of a ‘New Rural Cooperative Medical Scheme’ or ‘New Rural CMS’ – basically local health insurance – began in July 2003, in selected rural areas, to improve countryside families’ risk-resistance to serious disease.

This year, over 600 Chinese counties – 40% of the total – are experimenting with this new scheme, and central government intends to raise the proportion to 60% next year.

The scheme sets up a Cooperative Medicare Fund Pool in each county. A farmer pays 10 Yuan (US$1.25) into the pool for medical insurance; the central government, and the local government, each pay an additional 10 Yuan for each farmer who joins. In regions where the local government is richer, it is asked to pay more.

Throughout the three years of its implementation, this scheme has been a heated topic – both at home and abroad. Is it a success or a failure?

Wu Ming, Professor of Health Policy at Peking University School of Public Health, has been researching China’s New Rural Cooperative Medical Scheme in depth. She tells RealHealthNews that Central Government is to be praised for listening to its scientists, while researchers are responding to the needs of policy-makers.
If they bought the insurance for one year, but did not get sick that year, they would feel they had spent 10 Yuan for nothing and would be reluctant to join the insurance next year.

They also seldom bother to read printed materials, if they can read at all. So grass-roots workers go door-to-door, to explain the scheme. However, the explanations sometimes are not clear enough; so some farmers may join the scheme based on a misunderstanding, and later, some trouble may occur.

In 2006, the central and local governments increased their subsidy from 10 Yuan per farmer insured to 20 Yuan respectively, making each insured farmer have 50 Yuan in total in the fund. However, Chinese scholars hope that a system could be established to guarantee continuous improvement in the level of healthcare that farmers could enjoy, so that with the economic development of China, the fund could become larger and farmers in rural areas could enjoy more advanced medical technologies.

The scheme is expanding rapidly, aiming to reach nearly two out of three counties in 2007. “I know relevant people of all levels are enthusiastically working hard on this, which is good” says Wu. “However, as a researcher, I feel this rate of expansion may have some potential risk.”

“My major concern is the ability of local management and personnel. It could be a big issue. The scheme needs rather accurate forecasting of medical expenditure, in order to set up management plan. However, the calculations are not easy. Even the baseline investigation and baseline data collection are big barriers to untrained local personnel.

“For example, they need to know statistics such as the local state of health, inpatient and outpatient levels, past medical expenditure levels, disease types and farmers’ preferences when choosing medical care providers, and so on and so forth. However, the records [of such things] are quite incomplete. What is also difficult is that, when forecasting, one should take into account behaviour uncertainty: farmers’ usage of medical services could be quite different when there is insurance and reimbursement. To forecast under behaviour uncertainty needs lots of expertise” Wu explains.

“If the forecasting fails, there could be the problem of an overdraft on the fund, which could seriously hurt the next year of the scheme; or a fund deposit [an excess of funds], which damages the fund utilization efficiency.

“Many local health workers have no experience or expertise on forecasting. On the other hand, the numbers of forecast experts in China are limited – not enough to provide timely training to those grass-root workers across the country. If we expand too fast, problems may occur.”

Wu therefore proposes the prior creation of a mature intellectual workforce pool, through training, and the creation of other favourable conditions, before expanding the scheme to an even greater portion of China’s rural areas.

However, Wu is very pleased with the government’s attitude towards academic researchers. “The Ministry of Health often invites us scholars to symposiums for consultation. Our suggestions are very seriously treated. For the New Rural CMS, the Ministry of Health has especially formed an ‘expert-team’ composed of experienced scholars in the field to supervise the scheme and offer suggestions.”

“The policy makers and we scholars are working together to bridge the gap between academic research and policy making. On one hand, policy makers actively take academic instruction from us; on the other hand, we scholars focus more on how to link theories with real-world policy making. This is a two-way effort.”

“The greatest challenge is still financing” Wu told RealHealthNews. “Considerable portions of China’s rural areas are still quite underdeveloped. The local governments of those areas have very limited financial ability to appropriate more funds for local healthcare. This has resulted in the low health-service providing ability in the countryside and farmers’ low accessibility to healthcare. We are calling for international financial aid.”

For example, “a few ultrasonic B-scan machines [for breast cancer screening], some building repainting, solar batteries, and water supplies – these do not cost much, but would mean a whole lot of difference to the health services in China’s countryside.

If international donors were prepared to help but wanted to make sure their money was effectively used, they could invest selectively in medical services in rural areas. And they could ask for evaluation to make sure their money has really been used on poor farmers, not other things, Wu suggested.
Research what you like – amidst warfare

Nepal is ‘virgin’ territory for health research: so who dares wins

Sadly, many countries and regions of the world – including parts of the Middle East – are torn apart by warfare and endemic violence. The Kingdom of Nepal, with its continuing conflict between Maoist guerrillas and the elected government, is a sad but perfect example. Health care suffers. Doctors flee. But daring health researchers can continue to seek answers amidst war.

A senior medical expert – who has held a number of senior government advisory roles – disagreed. “Academic health research projects have not suffered” he said. “I know a number of field researchers going to the field for data collection and field trials – but there are many others who are also scared because of the present rebellion in the country.”

So it’s a question of daring and winning. There are great opportunities in research – but also mortal risks. Basic health research is essential in the country. Lack of statistics on the disease burden has hindered the prioritisation of health projects – although a little research has been done in women and children’s health, and in HIV/AIDS and other sexually transmitted diseases.

Health challenges are growing. “We have seen an increase in the HIV/AIDS as more and more Nepali men and women are forced to leave their villages in search of employment” said a researcher from Nepal Health Research Council. “And among the villages there are hospitals – but no doctors”.

“You won’t believe it but hospitals are being run by managers with no or very little medical training” said one medical doctor. “Doctors are too scared to go to the villages because there is no protection”.

And there is endemic violence in the towns too. According to a senior medical practitioner, doctors are being manhandled in the big cities like Kathmandu every day – but no one comes to protect them. “We are risking our lives!” he says.

Health and education in Nepal has improved – for those who can pay – through private sector initiatives. But Maoist leaders seem to be determined to nationalise these two sectors. And the Maoists seem to be in command, and not the elected government, which was reinstalled after an 18-month power tussle with the Nepali monarch.

“It is very good if the Maoists can pay for our patients in those eye care hospitals” said an ophthalmic assistant who has long been associated with prevention of blindness projects.

According to health researchers, there are already some common health research projects between Nepal and India on diseases such as kala azar. But they call for more and greater collaboration. The huge research base in India could help solve some common trans-border problems, they say, for example in malaria and HIV/AIDS.

by Prakash Khanal

“Nepal is a virgin country when it comes to health research because you can do research in any topic here,” a visiting researcher from the United States remarked some years ago.

In other words, in Nepal almost nothing was known, and everything was to discover.

It was true then. Surprisingly, it is still true. Back then, few Nepalis would indulge in health research. Today, political instability and the ongoing people’s war seems to have brought to a grinding halt what little research was going on in the field.

“How can you do health research in such a difficult situation when you can’t do field research or a field trial?” a senior official from the Ministry of Health asked RealHealthNews. “People want to do research but they are scared to go to field for any work. No-one knows what the Maoists will do next.”
Politics needs ideas – numbers come later

Quantification is the bane of social medicine

Nduku Kilonzo is Research Director of Nairobi’s Liverpool VCT and Care, a HIV/AIDS care facilitation and research organization – which began as an operational research project of the Liverpool School of Tropical Medicine. Kilonzo’s speciality is gaining evidence on the role of gender and rape in the AIDS pandemic – and even more powerfully, changing health policy and actions in response to her results.

RH N: Your research on improving the health system’s approach to rape victims is very personal – intimate in fact. How easy is it to get funding?

NK: It is a challenge, and particularly for work such as ours that’s not exactly biomedical. The people I talk to for funding say “where’s the significance in that?” – in the sense of statistical significance. And I say that you can’t look at systems as a statistic! You can’t say that I am putting an intervention in place and then look at it in numbers. You can look at the numbers that go through system, and show that it works, but there are certain things that are simply qualitative. And lots of people hesitate when I say this.

That’s one of the challenges that I’ve had, to get support for qualitative studies...

RH N: And isn’t this also a challenge to your career? You are an academic very much focused on action. But that’s not the typical aim of an academic department.

NK: To be honest with you, I’m one of the critics of academia. I’m an academic; but also a critic! I think that if we are saying that being an academic is about knowledge, and you restrict yourself to just one kind of knowledge, then you are opposing the very purpose of academia.

Most of the funding we get [at Liverpool VCT] is from development partners interested in the operations [of health systems]. So we collect data on this or that. But my experience has been that it’s becoming increasingly difficult to get people to fund qualitative work.

But in terms of career, there’s more hope – I really do think there is progress. We are seeing an infiltration of lots of social science perspectives into research. Particularly in medicine. And an acceptance that you can’t look at biomedical and curative medicine without looking at preventive and social issues and all those other drivers around ill-health and disease. And if that is a direction that we are seeing more and more, there have to be opportunities.

RH N: But there’s also a strong statistical approach to these approaches, isn’t there? Whereas you are saying that a lot of the important questions are really informal...

NK: Yes... And they are really socially based. I would say – for example - that you can’t measure perception, however much you try. You can say how many people felt this way or that, but you can’t measure a perception per se. My perception makes me decide whether or not I think I should take my child to hospital. I know these arguments have been gone over again and again but we keep blinding ourselves in the search for numerics.

RH N: You are asking for the kind of analysis that goes into disciplines like history, say – narrative argument - not something that the hard sciences are used to doing.

NK: Well my argument is that we need to infiltrate these things into the hard sciences! I’m a critic of the hard sciences, but I use the hard sciences! I’m a complete inside critic.

SUMMARY

Researching HIV/AIDS and rape victims in Kenya, and bringing her conclusions before policy-makers, have taught Nduku Kilonzo of the fundamental importance of verbal analysis and argument – both to clarifying understanding the issues, and to converting them into political response. Academia and donors should not be in thrall to statistics, she argues.
For example, I’m working currently on some of the arguments around the key social issues for the provision of PEP – post-HIV+ve-exposure prophylaxis. And in my experience, you can’t look at PEP from a biomedical perspective. Not PEP for sexual violence. Because you give PEP for a completely socially-located problem. So how you examine, and how you get your history, is all based on social locales.

For instance, I’m writing a paper at the moment, where I’m asking: what is the local understanding of sexual violence and what are the discursive practices around it? And how do those influence the kind of history a clinician is given?

Suppose you are a male clinician; I’m a female; and you expect me to come to you and tell you exactly, like in all the details, how I was raped? You must be kidding! And then you expect to use the history I gave you to do your evaluation and indicate my medication?

A social, qualitative approach challenges the whole biomedical perspective, but the arguments can be very solid – I can give the social locale, and explain how it influences or interacts with the biomedical perspective.

> RHN: You are calling for a different kind of argument...

NK: Yes. And I’m hoping this paper will get published, looking at medicine and academia and infiltrating into that other issues that are very relevant to effective care but have been pushed to the periphery.

To me that’s very important. And how that links with policy, and to what RealHealthNews is doing, is this. I don’t have any evidence for this, but my experience is that policy is not directed by numbers.

Numbers form a very solid basis for your argument, but your argument has to be directed by other considerations. Numbers and evidence are so very basic to whatever you are going to do, but I think you can only use your evidence and your numbers after you have convinced policy-makers that your argument is worth listening to.

That’s when they ask about the evidence. They don’t ask about the evidence before the idea makes sense!

> RHN: That’s fascinating – so they need a convincing argument, a verbal argument, first.

NK: Yes, and the verbal argument, in my understanding, has to resonate with the political, economic and social interests at that point in time.

> RHN: So first you get the policy, and then you work out the evidence to support it!

NK: But if you have no evidence, it’s highly likely for that idea to completely die off. But you can’t even begin to present the evidence without something above that. That’s what engages policy, in my opinion.

But I don’t have evidence for this! I haven’t even begun to tease out what the issues, what the interactions, what the intersections are. What are the pathways that in my experience I’ve been able to use. I’ve not even teased that out intellectually. But it’s something I’m beginning to get more and more of a sense of as I do lots of my work.

> RHN: You are really forging a new line here!

NK: I’m hoping so! But you see this is not the kind of thing that you are going to write in any scientific paper. Because it doesn’t have evidence. ■
Kenya's hardy women researchers

Women in health research must fight gender stereotyping

SUMMARY

Kenya needs more women health researchers, but gender stereotypes, exploitation and rejection may face them in the research community. It is time that attitudes changed, for the good of health research, says Monique Wasunna, Deputy Director of the Kenyan Medical Research Institute, KEMRI.

by Ayoki Onyango

It is said that over the last two decades, the number of women scientists working in public and private sector research in Africa has been slowly increasing. But this does not appear to have happened in Kenyan health research – despite the fact over 60 per cent of the total population are women, and despite increasing numbers of girls who are rising through education in primary, high schools, colleges and universities. Statistics indicate that of women who are enrolled in universities, few do health related courses.

So what is keeping them away? Monique Wasunna, an expert in leishmaniasis and Deputy Director of the Kenya Medical Research Institute (KEMRI), and Director of Clinical Research, says that among the leading impediments are gender perceptions and stereotypes. “Some students get discouraged just at the moment when they start choosing careers, while still school” she says.

She says more girls should be encouraged to take science subjects in schools to enable them do courses like medicine. “My male lecturers kept on telling me that taking career in health research would tax me when I became a mother of a family. But I just insisted on doing what they discouraged me to do” she says.

Wasunna says that although women who venture into health research begin on an equal footing with men, a recent study by the Institute of Civic Education indicates that women face more obstacles than their male counterparts.

She says the obstacles arise not only in [dedicated] health research facilities – but in all institutions where health research work is carried out. Research done in public universities, for example, is competitive – and in most cases men are favoured against their female counterparts.

“Women health researchers also experience multiple role conflicts and negative traditional culture, which would confine them in their homes rather than letting them travel to other places, which is often essential in health research.”

Within health research, women health researchers are also treated as intruders – particularly when they compete for research funds.

Worse still, says Wasunna, is that most of their accomplishments are undervalued or discounted by their peers – who take advantage of their inexperience to acquire resulting research funds for themselves. Sometimes women are also sexually harassed. As a result their careers develop slowly, compared to those of their male counterparts.

These women researchers, however, are not passive victims, said Wasunna. They are active and resilient, developing various strategies to resist, subvert, overcome or cope with the daily realities of their lives. Indeed, a majority of those who make it past all the obstacles survive and thrive within the Kenyan academia, she said.

“Just like men, women are essential to quality health research” said Wasunna. Moreover “…women are the primary caregivers in most African countries - and the rest of the world homes. They tend to have a greater understanding of the role that the outside environment – things like family, community and stress – play on an individual’s health and recovery from illnesses.”

“Women tend also to exhibit patience, partnership, and perseverance, which are essential to collaborative multicentre research. Even the computer software mogul Bill Gates, has noted the importance of collaborative research in his recent funding of HIV/AIDS researchers.”

But added Wasunna: “Women should do all kinds of research – just as men should not be limited to specific gender areas, nor should women. Nevertheless of course it is important that more women be involved in research that relates to women and children, such as reproductive health, preventative health (like nutrition and protection against sexually transmitted infections), and maternal and child health.”

“And because of women’s empathy and valuation of family, it is also important that women be involved in research on neglected diseases, which tend to impact the powerless and the poor in the most rural settings.”

continued on page 24 >
“Having female health researchers to explain to mothers the need for treatment and control of disease vectors is essential to creating a relationship of trust…”. And in health care and prevention, “...women could serve at the forefront especially for malaria, leishmaniasis, and HIV/AIDS – health education is the key to this” said Wasunna.

So what is the solution? “In Kenya, we have started to see some investments in developing young women, and we do have a number of women in prominent positions at academic and state health research institutions” said Wasunna. “However, we are still counting women on our fingers and not by the barrels – when you realise that the ratio of Kenyan male to female doctors and scientists is 4:1.”

“We need a greater change of attitude in the research community – one which appreciates that different sexes bring different yet synergistic talents that will make the community as a whole stronger.”

“Scientific learning and testing that has traditionally emphasized aggressive competition should become more focused on collaborative problem-solving (we use that in a leishmaniasis research partnership I belong to, LEAP); and girls at a younger age should be encouraged to feed their curiosity about nature and science.”

“Issues of poverty need to be addressed as poor people tend to suffer from ill health more frequently. Women will contribute immensely to health research if given enough and equal opportunities.”

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**Opinion – HIV/AIDS in the Middle East**

**Time to lift the veil on AIDS**

Countries in the Middle East argue that Islamic practices protect them from HIV. How true is this?

**SUMMARY**

Is there such a thing as a “social vaccine”, behavioural norms that slow the HIV/AIDS epidemic in the Middle East? Shereen El Feki, former health correspondent of *The Economist* and presenter of the "People and Power" programme on *Al Jazeera International*, considers the question needs research.

**by Shereen El Feki**

When my father was growing up in Cairo in the 1940s, he got hooked on the famous fictional British detective, Sherlock Holmes. One of his favourite exchanges was the famous “curious incident of the dog in the night-time” from the novel Silver Blaze. The dog, of course, did nothing, which was what was so curious.

I was reminded of my father and Holmes when looking at statistics on the global AIDS epidemic. This year marks the 25th anniversary of the discovery of HIV, the virus that causes AIDS. According to UNAIDS, there are an estimated 40 million people infected with HIV around the world, and almost three million died of AIDS last year.

Epidemics on this scale transcend medicine, spilling over into international politics and economics. At the end of May, the UN held a special assembly on AIDS, dissecting progress to date and pondering what sort of prescription will halt the spread of the disease by 2015 – one of its Millennium Development Goals.

In a world awash with HIV, there is, however, the curious incident of the
Middle East, which seems strangely untouched by the disease. According to UNAIDS, there are more than 400,000 people living with HIV in the Middle East and North Africa – just 0.2 per cent of the population. But compare that to south of the Sahara, where, on average, 6 per cent of the population – around 25 million people – are infected with HIV.

So what is going on? Are Arabs somehow immune to AIDS? Many in the region think so. It is argued that AIDS will never be an Arab problem because Islam takes a hard line on practices which spread the virus – such as homosexuality, prostitution, and intravenous drug use. And when AIDS does rear its head at home, we tend to blame foreigners for it – most famously in Libya, which in 2004 sentenced six Bulgarian and Palestinian healthcare workers to death for allegedly infecting more than 400 children at a hospital in Benghazi. (The sentences have since been overturned, and the foreigners face retrial.)

The notion that religion or culture can serve as a vaccine against AIDS is not unique to the Arab world. There are plenty of other countries – India and China among them – which once argued that their culture and traditional values could protect them from AIDS – and which now find themselves struggling with the epidemic. Nor are Islamic societies uniquely protected – just look at Indonesia, the world’s most populous Muslim country, where infection rates have soared in recent years.

The trouble is, of course, that official statistics on AIDS in the Middle East do not tell the whole story. They largely reflect AIDS cases which turn up in hospitals, or migrant workers who have been tested for their visa applications. To get a picture of the real state of HIV in the Middle East, you need to test those at highest risk, but such surveys are rare.

Not only does stigma prevent people with risky behaviour from volunteering, but in many Arab countries their practices are illegal – hardly an incentive to step forward. Poor availability of confidential counselling and testing does not help; nor does the prospect of deportation by some Gulf states if foreigners are found to be infected. And with a scarcity of antiretroviral drugs, there is little interest in being tested if there is little hope of being treated. So those who claim that HIV is not a Middle Eastern problem are simply shouting in the dark.

To be sure, there are many features of Arab societies which may have slowed the spread of AIDS in the past, such as strong family networks and practices such as circumcision. But the Arab world is changing in ways that make it vulnerable to HIV.

UNAIDS notes there were more than 60,000 new infections of HIV in the region in 2005, about the same as North America or Western and Central Europe.

As economies liberalise, migration and trade are opening new avenues for AIDS in the Middle East. Conflict makes it easier for HIV to spread. Sudan, long plagued by violence, has seen its epidemic move from high-risk groups to the population at large, and there are concerns that the war in Iraq is making inroads for HIV.

The relative youth of Arab societies also puts them at risk. Almost 60 per cent of Middle Easterners are under 25, ripe for the sort of sexual experimentation they see on satellite television and the internet. Young people are delaying marriage – in part because they cannot afford it – but their sexual needs are not so easily put off. Yet schools provide little education about sex or protective measures, such as condoms. And although many Middle Easterners are reluctant to admit it, prostitution and homosexuality are long-established facts of life.

But it is not all bad news. There is a dawning recognition in the Arab world that AIDS is now also a home-grown problem. There are attempts to promote awareness, prevention and treatment – the UN, for example, is training hundreds of imams and priests across the region to spread the word about HIV. Moreover, the Arab world has a once-in-a-lifetime opportunity to tackle HIV early enough in the epidemic to stop it in its tracks. People are literally dying all over the world for such a chance; now is the time for the Middle East to lift the veil on AIDS.
In the last three years, efforts to test the AuthorAID concept have garnered expanding interest in the worlds of science, development assistance, publishing, and editing. AuthorAID, as a concept, has its origins in three key observations:

- Researchers who are closest to the problems of poor health and poverty in developing countries rarely manage to publish their work where it can have the greatest impact on policy, practice, and ongoing research.1,2,3 (Impact here denotes influence on policies, practices, and research to alleviate poverty and poor health, rather than the conventional use in science publishing, as in impact factor.) Thus AuthorAID focuses on helping authors from developing countries communicate results and ideas to those best able to put them to use.

- Many scientists worldwide who have published extensively are at or near retirement, and are willing and able to serve as mentors to developing world researchers who want to publish their work, taking on one manuscript project per year.

- Research institutions and researchers with abundant resources often employ developmental editors, often called author’ editors, to increase the chances of publication in the chosen venue. Many of these editors have offered to donate time to AuthorAID, providing teaching materials and working with authors from developing countries.

In 2003, the Rockefeller Foundation asked the editors of the Journal of Public Health Policy to serve as developmental editors for 10 groups of health researchers based in more than 25 countries, International Health Research Awardees. The Foundation and the researchers wanted their work published where it would have the greatest impact in local languages and in English. This was the first opportunity to test an element of AuthorAID.

From the perspective of development assistance, and research capacity strengthening in particular, AuthorAID constituted a missing element. If the results of research in developing countries were not disseminated by publication, the investment in research capacity, both by the countries and by the development agencies, was less than fully effective in fighting poverty and poor health.

Confident that developmental editing assistance could often make the difference between acceptance with publication and rejection, the JPHP editors presented the concept to many groups: the World Federation of Public Health Associations, the Global Forum for Health Research, the Council of Science Editors, the European Association of Science Editors, and the Center for Global Development.

When Richard Horton, 2005 President of the Council of Science Editors, formed a Task Force on Science Journals, Poverty, and Human Development, it adopted AuthorAID as its project. The Task Force chairperson, Paul Bozuwa, proceeded to solicit and receive small underwriting contributions for AuthorAID from CSE itself, Science, Nature, Cell, PNAS, EHP, and others. CSE will use its website to test informally the AuthorAID concept, posting requests for help and offers of volunteer assistance.

AuthorAID focuses initially on science and development, but conceptually is far broader. The concept could be applied in many disciplines, in many languages and regions, and for many forms of writing. The JPHP editors simply made a strategic decision to focus on scientific research and policy articles that might influence policy, practice, and future research. This reflects their longstanding interest in “research to policy,” and early interest from...
international science journals suggested that starting there would attract the greatest attention.

The JPHP editors have also resisted suggestions that AuthorAID start with a health focus alone. With a planning grant from the Swedish International Development Agency’s research division, they sought an institutional home from which to test the concept in a carefully evaluated project – in a particular field, language, and form of writing. Will AuthorAID work? If so, can it be replicated and expanded?

In mid-July 2006, the report on the planning project informed Sida that the International Network for Availability of Scientific Publications (INASP) had been chosen to host the AuthorAID test. Two developing world research networks, one working on biological and water resources at the International Foundation for Science and the other covering infectious diseases at the Tropical Disease Research programme (TDR), have offered to work with INASP to target researchers who could benefit from developmental editing help.

Two key elements emerged from early discussions:

- A web-based programme would match developing country authors (with promising manuscript projects) to scientific mentors and author’s editors - who would then collaborate to help the author write and publish the manuscript. (Mentors would never accept or request authorship, but would receive generous acknowledgment.) The process would be managed on the Internet with software for collaboration and tracking.

- A web-based knowledge community would focus on communicating science effectively, to make it easier for developing world authors to find and share information for preparing articles for publication. A knowledge community can facilitate sharing content and ideas with peers, with editor/mentors, and with others who share interests and needs. (As the site would be open to all, policymakers may find it a useful way to stay on top of developments in their fields.) It could create dynamic interest groups, information collections, and channels for monitoring and exchanging information. By building profiles of user interests and by using taxonomies that reflect those areas of interest to classify content assembled by the AuthorAID staff, submitted by users, and gathered from a wide variety of other sources, the system could match users with each other, with the information they need, and with opportunities to participate in exchanges of experience and knowledge. The knowledge community would also maintain a repository of manuscripts, in all their stages, assisted by AuthorAID. Authors, once published, might choose to open access to their manuscripts in the repository.

INASP suggests that in addition to these two components, that it would be helpful to use local workshops in developing research institutions to teach about AuthorAID and learn more about authors’ needs.

The World Federation of Public Health Associations, with which JPHP is affiliated, provided an opportunity during its August meeting in Brazil to explore further demand for AuthorAID. Public health leaders from Vietnam and Hungary spoke of the need for developmental editing assistance in their two regions, Southeast Asia and Central Europe. Most recently, the International Society for Environmental Epidemiology has decided to provide AuthorAID-type assistance to its developing country members who want help preparing manuscripts for publication. The Society, with about 1000 members, has a large number of senior researchers, in both industrial and developing countries, who have volunteered to mentor their junior colleagues.

Remembering that AuthorAID is first and foremost a concept, we invite anyone and everyone to use the idea in the spirit in which it was conceived, to help those would write to communicate do so more effectively.

For more detailed information, please contact Anthony Robbins at: anthony.robbins@tufts.edu or Phyllis Freeman at: phyllis.freeman@umb.edu


Japan’s health revolution to be bestowed on Africa

by Andy Crump1 and Taro Yamamoto2

Japan is bringing its resources and own unique philosophy to bear on Africa, as part of a major new initiative to help achieve the Millennium Development Goals (MDGs). This will be a key element of the new US$ 5 billion Health and Development Initiative (HDI)3, which will help extend Japan’s “village living” concept to communities across Africa.

Japan’s overseas development assistance (ODA) had been in decline following the bursting of the Asian economic bubble. Nevertheless, at the 2005 G8 Summit in the UK – at which all donors agreed to increase aid to Africa – Prime Minister Junichiro Koizumi reported that Japanese ODA would double, with a further US$10 billion being given over the next five years. This included a pledge to double Japan’s aid to Africa over the next three years, much of the new aid being disbursed through the new, comprehensive US$ 5 billion pro-equity HDI.

So will the HDI be more rhetoric, another initiative that will fail to meet its goals and drift into obscurity along with the many African-centred programmes that have preceded it? The evidence suggests not – and prospects for it having a substantial impact are good.

The Japanese experience

Japan has successfully undergone full-spectrum development in modern times. In post-World War II Japan, the picture was much the same as that prevailing in many of the sub-Saharan countries today. However, Japan rapidly developed the infrastructure, skills and resources needed to promote development, improve health and wellbeing and alleviate poverty.

Over less than 20 years, Japan drastically reduced its own infant and maternal mortality rates, eradicated infectious diseases such as malaria, leprosy, schistosomiasis and filariasis, markedly cut the impact of killer diseases such as tuberculosis, established a thriving economy, and produced world-leading living standards and social welfare systems for its entire population.4

This was accomplished through a comprehensive, community-based approach encompassing school-based interventions, improved nutrition, provision of potable water and sanitation, community involvement, building of institutional capacity, cohesive operation of research and control programmes, and via the creation of effective and reliable health systems and insurance with universal coverage.

A comprehensive strategy engaged all sectors, promoting community ownership, using science-based technologies and proven products, making best use of funds provided from local and external sources. Public and private sector agencies were engaged to ensure that knowledge was transferred and that best practices could be extrapolated into nationwide use. That is the philosophy behind the assistance that Japan is offering to Africa.

The global scene

On the global stage, Japan has already played a leading role in efforts to eliminate diseases such as smallpox, polio and leprosy, and has originated several global health ventures that benefit the developing world, particularly with regard to infectious diseases. These include the Global Issues Initiative on Population and AIDS (1994), the 1997 International Parasite Control Initiative (also known as the Hashimoto Initiative), which proved to be the forerunner of the Global Fund to Fight AIDS, TB and Malaria (GFATM), and the Okinawa Infectious Diseases Initiative (IDI), which began in 2000.
In 1993, Japan recognised the decline in global interest in Africa following the end of the Cold War, and consequently convened the first Tokyo International Conference on African Development (TICAD). Since then, it has extended over US$ 12 billion in aid to the continent and regularly holds TICAD conferences, the next being scheduled for 2008.

In addition, Japan has just announced the establishment of the Hideo Noguchi Prize, a US$ 1 million award envisaged as the equivalent of a Nobel Prize for outstanding contributions to medicine in Africa, to be awarded every five years at each forthcoming TICAD.

Japanese midwife carrying out a home visit to check the health of a mother and newly-born twins in Côte d’Ivoire.

Even with no initial itemized budgeting, Japan's funding promises have always been honoured. The IDI, for example, was planned to see expenditure of US$ 3 billion over 5 years, yet some US$ 4.1 billion was spent in four years, as well as 735 experts being engaged, 3 088 volunteers participating in activities and 15 278 individuals from developing countries traveling to Japan for expert training.

Another example is that of January’s International Pledging Conference on Avian and Human Influenza in Beijing, where participating nations pledged a total of US$ 1.9 billion, out of which a meagre US$ 300 million was disbursed as of the end of April 2006. Japan was one of the few donors that fully disbursed the funds that it had pledged (US$ 155 million).

**The HDI strategy**

The HDI activities in Africa will aim to:

- **Improve human security with national perspectives**, by creating environments/situations/circumstances in which individuals can protect themselves from health problems through provision of quality health services, access, prevention education and enlightenment.

- **Improve individual knowledge of diseases and ways of avoiding ill health**, including the development of appropriate knowledge management systems, telecommunications networks and information, education and communication (IEC) materials.

- **Stimulate intersectoral action to strengthen overall health systems**, delivery systems and access, especially with respect to creating gender equity and correcting community-level disparities.

- **Collaborate fully with donors and international organisations to harmonise efforts and ensure that interventions are sustainable and not duplicated**.

- **Develop programmes and activities according to needs identified by partner nations and that fit into successful strategies already in operation**.

- **Strengthen capacity with respect to local conditions, environments and available resources and prospects of sustainability**. Particular attention will be given to operational research and monitoring and evaluation capabilities.

- **Integrate health concerns into all infrastructure development projects**, notably those related to water supply, sanitation, irrigation and school building.

**The Africa side**

Africa is full of entrepreneurs and overflowing with enterprise. African nations themselves have already embraced
mechanisms to tackle problems in concert, creating the New Partnership for African Development (NEPAD) in 2001, a strategic framework for elevating living standards through improved local governance, better global trading and financing and intensified focus on priorities such as education, health and building critical infrastructure.

Japan will provide some essential supportive resources and technical assistance specifically targeted to curb the spread of infectious diseases, reform and strengthen national health systems and staff, improve education and promote agriculture and private sector development.

In particular, to support the improvement of rural lifestyles and self-reliance in Africa, based on the notion of human security and mindful of its own post-war progress, Japan is promoting an African Village Initiative, through which it will support rural community development and empowerment of communities. It will be working closely with the UN Millennium Project to promote the innovative African Millennium Village (AMV) initiative.5

Each of the 12 clusters of AMV is located in a distinct agro-ecological zone – arid or humid, highland or lowland, grain-producing or pastoral – to reflect the range of farming, water, disease, and infrastructure challenges facing the continent and to show how tailored, science-based strategies can overcome each one of them.

HDI: Specific goals

Health

- Vaccination initiatives, particularly for measles and polio, including provision of vaccines and support for diagnosis, surveillance and vaccine production.
- Voluntary counselling and testing for HIV/AIDS and provision of testing kits.
- Scaling-up of anti-retroviral therapy (ART)
- Programmes to protect AIDS orphans and to help prevent child labour, abuse or other forms of exploitation
- Improvement of systems to help ensure safe blood supply.
- Provision of Oral Rehydration Salts (ORS) to combat diarrhoea.
- Provision of antibiotics to tackle Acute Respiratory Infections (ARI).
- Provision of vitamin A and iodine to improve nutrition.
- Provision of insecticide-treated bednets (ITN) to combat malaria and other insect-borne diseases, as well as appropriate anti-malarial.
- Provision of anti-TB drugs and test kits and to encourage use of the DOTS strategy.
- Support for school-based health interventions, in particular human resource development to tackle parasitic diseases of poverty, such as filariasis, schistosomiasis, trypanosomiasis, onchocerciasis, dracunculiasis.
- Promotion of Integrated Management of Childhood Illness (IMCI) and ensuring of regular health check-ups for infants.
- Promotion of maternal health and access to best-available and appropriate reproductive health systems and products.
- Prenatal check-ups and distribution of Mother-and-Child health promotion materials.
- Health education and awareness.

- Development of national and continent-wide disease surveillance systems to help detect epidemics and to integrate seamlessly with global initiatives.

Health Related

- Installation of systems and provision of safe water (especially in schools).
- Installation of community waste disposal systems, latrines and sanitation systems (especially in schools).
- To combat malnutrition through boosting of agricultural performance (in collaboration with the Consultative Group on International Agricultural Research (CGIAR), including the promotion, development and diffusion of NERICA (New Rice for Africa), improvement of small-scale irrigation (in collaboration with WFP and others), provision of fertilizers and farm equipment, and equalising access through development of local and feeder roads, local markets and industries.
- Support for the African Village Initiative, by advancing rural community development via a combination of empowering communities and infrastructure development – in particular, working with the African Millennium Village Project, which will provide a proving ground for scaling-up a variety of innovative technologies.
- Creation of opportunities for exchange of technology, skills and training cooperation.
- Encourage the establishment of networks of specialised institutions, especially South-South, as well as facilitating novel Public/Private partnerships.
- Widespread dissemination of best practices and successful interventions.
- Provision of medical equipment, medicines, ambulances, hospitals and clinics and adequate, safe and reliable procurement, storage and delivery systems.
- Rehabilitation of basic infrastructure such as roads, power supplies and communications systems.
The AMV will come in three types, with each village having guaranteed funding for five years. The Millennium Research Villages (Type 1) represent the fundamental core, where interventions will be rigorously monitored, their outcomes quantified, and proof-of-concept established. The villages, each with an aggregation of about 5,000 people, aim to demonstrate a model for achieving the MDGs that can be scaled up in all senses: concept, implementation, financing, monitoring and evaluation. Japan is supporting research villages in Ghana, Kenya, Malawi, Mali, Nigeria, Senegal, Tanzania and Uganda.

Upon ‘proof of concept’ of their broad-based, community-led development strategies, the interventions will be scaled up to encompass 330,000 people in Type 2 AMV, which will be clustered around the Type 1 villages. This will enable communities to benefit from economies of scale in infrastructure, including roads, district hospitals, electricity grids, water and local market expansion. Through the concentric expansion of Type 1 village programmes, costs can be lowered, investments shared, and knowledge distributed.

The key elements of rural development strategies are known, yet the full range of essential interventions has thus far neither been applied at scale as part of a community-led development initiative nor subject to realistic budget constraints or critical scientific monitoring. Millennium Research Villages are designed to rectify this.

Geoffrey Sachs, Director of the UN Millennium Project, indicates that the “groundbreaking partnership between the Millennium Project and the Government of Japan will be fundamental in showing the world that through practical and affordable interventions combined with community empowerment and leadership, the fight against extreme poverty can be won, even in the most impoverished and difficult areas in the world.”

The impact

Countering past criticism, much of the HDI funds will be disbursed in the form of grants – not loans – including an additional non-HDI US$500 million for GFATM. Since July 2005, Japan has extended well over US$312 million in bilateral Grant Aid (Exchange of Notes) to sub-Saharan Africa.

This includes US$32.8 million for underprivileged farmers, US$49.5 million to health programmes, primarily for infectious disease prevention in children, US$40.9 million for school building and development, together with US$22.6 million for water development projects and irrigation schemes. Japan has been the largest donor for water/sanitation projects since the early 1990s (Japan gave US$4.6 billion between 2000-2004, representing 41% of the global total). The new Water and Sanitation Broad Partnership Initiative (WASABI), announced at the 4th World Water Forum in Mexico in March, will strengthen Japan’s contribution still further.

The flexibility inherent in Japan’s approach is illustrated by the fact that US$2.5 million has already been spent in Nigeria and Niger on public awareness campaigns related to the recently-recognized Avian influenza problems. In August, Japan provided UNICEF with US$4.5 million for life-saving vaccines, bednets and other health-care services for Sudan, adding to the US$10 million already provided for Sudan-based activities this year. UNICEF was given a further US$4.2 million grant for polio immunization and malaria prevention in Nigeria.

In all, during fiscal 2005, well over US$620 million has been provided in HDI bilateral grant and loans, excluding technical cooperation. It is likely that, at the conclusion of the HDI, disbursement of funds may well resemble the distribution seen at the end of the IDI.

In collaboration with its partners, Japan’s HDI - based on the policies that enabled the country to bestow world-leading longevity on its own citizens, create excellent health, welfare and economic systems and establish the nation as a true world leader, all within 20 years - will go some way toward accelerating equitable progress and enhancing the lives, freedoms and opportunities of those most in need.
Governments to develop global research strategy by 2008

WHO members will seek new incentives for R&D for the poorest

At the last World Health Assembly, Kenya and Brazil pressed for members to agree a “framework” for global health research for resource-poor countries and communities. The word frightened some states, but they agreed to look for new incentives in addition to intellectual property.

There was agreement that the new working group would “look for the low-hanging fruit, to be harvested within a year”, including a special focus on essential health research; and to conclude that work within two years, he said. Furthermore there was agreement “not to decide now what was in or out, but to give the mandate to look at the whole range of recommendations from the Commission” [the CIPIH].

Silberschmidt’s trick appeared to have been to agree at the outset that the WHA would not be creating a “framework” – as requested by Brazil and Kenya – but rather a global strategy and plan of action. This meant “a moral commitment that provides a framework”.

S U M M A R Y

At the last World Health Assembly, Kenya and Brazil pressed for member to agree a “framework” for global health research for resource-poor countries and communities. The word frightened some states, but they agreed to look for new incentives in addition to intellectual property.

> by Robert Walgate

Well it’s only an agreement to talk towards a global research strategy and new incentives – but in diplomacy that can be a long step forward.

This conclusion and several others were reached by combining two previous draft resolutions: one based on a recommendation at the January Executive Board by Brazil and Kenya that there be a global framework on essential health research and development; and another based on the recommendations in a report from the Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH).

All sides warmly commended Gaudenz Silberschmidt of the Swiss Federal Office of Public Health, who chaired the negotiations, on his success. Speaking to RealHealthNews after the decision, he said the discussions had been difficult “but there was a surprisingly positive mood”.

It’s now a question not whether IP is needed or not, but what other incentives are needed in addition to IP, to get new treatments to people where paying markets are poor, Silberschmidt believes. “We shouldn’t listen to the fringes of whether IP is good or bad – I don’t want to go back to that deadlock… the more time we lose discussing that the less time we have to discuss real implementation of what’s needed.”

“I hope for a Global Strategy and Plan of Action with real, concrete steps forward” said Silberschmidt. But that progress will come in small steps and details, not in headlines, he believes.

Further information:


Papers are invited, especially from health researchers – and policymakers – in developing countries. They should be short, well-founded arguments and opinions on matters of significance to health and health research policy-making.

Letters to the editor are also welcome.

All our stories and more, in some cases extended and with links to web resources, can be found on the RealHealthNews pages at www.globalforumhealth.org

RealHealthNews is supported by the Global Forum for Health Research. Views expressed are not necessarily those of the Global Forum.

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