Goa, health at the front line

Health seen from the ground shows the real problems

Palestine unites for research plans

Even countries in deep conflict can unite behind the idea of science to improve health, Palestine shows. The first of a series of studies on connecting health research with policy-making in low- and middle-income Arab states has Palestine lighting a beacon for others to follow.
>RHN: Could you give us an outline of the health situation and the chief health problems in Palestine?

JOAN JUBRAN: Well you should take into consideration that Palestine is under occupation, so the development of the health system is extremely affected by that, and even by the internal political situation – I mean what is happening now in Gaza and the West Bank, with Hamas and Fatah. With the Israeli occupation within the Palestinian territory, that is the West Bank, and in Gaza previously, we’re talking about the segregation of land in the West Bank. For example, we’re talking about a village five kilometres away from another, but to get between them you have to take long bypass roads and travel through checkpoints.

We’re also talking about the Israeli separation wall, which is within the West Bank territories, within the internationally agreed 1967 borders. So we’re not talking about security any more, separating Palestinians from Israelis, we’re talking about occupation within the West Bank.

So we cannot talk about the health system as a coherent health system, because you’re talking about three different parts within the West Bank. The north, the midlands, and the south, are totally separated. And the hospitals, for example, are concentrated in the centre, Ramallah, and the people in the north find it difficult to access specialised hospitals there.

>RHN: Can’t they pass down through Nablus, for example?

JJ: They do, but it takes more time. Sometimes you hear about cases of women who have given birth at checkpoints or people who weren’t able to get kidney dialysis because of the delay at checkpoints.

>RHN: Are these checkpoints throughout the West Bank?
JJ: Yes. There were, I think, 300 within the West Bank, but now they have been reduced somewhat.

>RHN: So you are saying it’s very hard, if you need it, to get to a health centre? But what about the bottom-line statistics? A lot of the published statistics, for example on education in the West Bank, are very good, aren’t they? So how do you stand on the standard sorts of developing country indices like maternal mortality and infant mortality? For example the health budget per dollar of GDP in Palestine is actually quite high, I believe. The average in OECD countries is 9%, and I believe it’s something like 13% in Palestine, so despite the external and internal violence there appears to be a high priority placed upon health in Palestine. Is that right?

JJ: Actually before the year 2000 many of the indicators, even the infant mortality, were better than in other developing countries, so yes, Palestine stood high in terms of its health status. Then in 2000 you know that there was the Second Intifada [Palestinian uprising], and so there were lots of factors that influenced the health of the Palestinians so this has deteriorated a little bit.

But even that wasn’t a major issue [for health] because there was a lot of international donor aid to Palestine for the development of the health sector, so in general the indicators are generally not that bad in comparison to other developing countries. Did you know that there was a lot of effort, for example, up to the year 2000, to decrease the infant mortality rate and provide programmes for maternal health? So the indicators are not that dramatic and we have witnessed an improvement until 2000. However, during the last few years some of the indicators dropped.

>RHN: One of the interesting things I notice about your report is actually how you did it, because despite the problems you’ve outlined you appear to have been very comprehensive. You’ve looked at every side of the issue and you’ve involved, as it appears to us, people from the ground right up to the ministers and also the academics. Is that right?

JJ: Yes. Actually this study is part of a larger one in non-oil Arab states, and I also participated in how the research was conducted in other countries. I noticed that in Palestine and Lebanon mostly, the participation of civil society, and even the interaction with the government and the unions was very easy. What it showed me is that we have a viable civil society.

It also showed that the connection with the government was not that difficult for us. In other countries, for example in Egypt, there were problems with meeting the government officials. We had the same methodology, but sometimes we had difficulties. But in Palestine, in our focus group we had many different stakeholders participating, from the ministry, from civil society, unions, researchers, and this enriched the discussion because we heard different opinions.

>RHN: Why do you think that was possible?

JJ: I think we’re used to that. Probably because of the status of Palestine, and the occupation before, civil society found a very important role in the provision of services – before we had the PNA [Palestinian National Authority, created by the signing of the Oslo accords between Israel and the Palestine Liberation Organization in 1993], I think we have a democratic and participatory approach to dealing with different issues. It’s not only in health; this is done in other areas too.

>RHN: I see, that’s interesting. You’re saying that at the ground level there’s a kind of informal democratic government - despite the political conflicts.

JJ: Yes… and because in the health sector, before the creation of the Palestinian National Authority, civil society was the provider of health, education and social services. When the PNA came we had policy dialogue with the government to implement some partnerships, and there are some clinics that are jointly implemented or are managed by the Ministry of Health and civil society organisations.

>RHN: To analyse that a little bit, would you say that’s because ordinary Palestinian people feel under threat and, therefore, bond together?

JJ: Yes, probably. We saw that in the Second Intifada, where this was very evident as emergency committees were formed because we couldn’t get medication and services through. Committees were formed between the government and the NGOs, so, yes, probably because we are under threat, and we have to cooperate because of the situation here.

>RHN: Let me come on to some of the real content of your report. Under the ‘main policy concerns’ you mention an over-dependence on donors. What fraction of the budget is donor-originated?

JJ: Actually one major problem with policy and planning in Palestine is that we don’t have exact figures for how much we depend on donors, because the PNA budget is separated from what we get from donor assistance. The national budget submitted by the Minister of Health, for example, for the health sector, does not incorporate donors’ funding, although we have a major dependence on it. In 2002, donor funding for the health sector reached 48%.

>RHN: One of the things that many developing countries complain of is that they’re actually driven by the donors; and there are many different donors, so they get lots of conflicting and overlapping programmes and demands on human resources

“We cannot talk about the health system as a coherent health system, because you’re talking about three different parts within the West Bank. The north, the midlands, and the south, are totally separated.”

JOAN JUBRAN

• May 2008

RealHealthNews • the magazine of real action and research • No. 9 • May 2008
for actions and reporting, and so forth. Do you face the same problem in Palestine?

JJ: We do face it, actually, but it wasn’t ever one of the discussions [during the making of our report], but we do face it.

>RHN: Well if it didn’t come up at the discussions it wasn’t important.

JJ: It’s probably because we influence donors. Not every donor or every agenda but, as we say in the report, we mention that projects are donor-driven.

>RHN: Ah, they’re more prepared to listen to you, maybe, than they are to some other people?

JJ: Yes.

>RHN: Or you make your points more forcefully!

JJ: Maybe. Also, yes, we talk more! [Laughing]

>RHN: Let me come right on to the conclusions. One of the things that’s striking about this work, as I said, is that it wasn’t purely an academic exercise and that you involved everybody – and yet you’re talking about research priorities. Now, usually in a typical research academic environment, these research priorities are defined by the researchers themselves, alone or in committees, with some important steerage by the amounts of money available from government. But here you create a whole series of research proposals that are originating from integrating civil society, and government, and researchers. What occurs to me is will they be acted upon and, if so, who will act upon them?

JJ: I hope they will be acted upon. The challenge, and you frequently refer to it in your magazine, in RealHealthNews, is how research can help policy, and how can we link research to policymakers. This is a major problem in Palestine because we do lots of research and it does not get implemented into policy. This is why also we tried to gather all the stakeholders, from policymakers to researchers, and to try to see how we can cooperate.

So now this has been put on the agenda of the newly formed committee for national policy and strategic planning, and it includes research institutions and civil society providers, health providers, and the Minister of Health, Minister of Planning, Minister of Finance. It was a very good step and they have put into action some areas for implementation, including some that were mentioned in the report.

Yet there is no national driver for [connecting health research with policy], unfortunately. Research institutions are separated from the governmental body. But the governmental body has also put in place a new health policy and planning unit.

And the thing is that of course all of this can become stagnated by the political situation, or by a change of minister, or whatever happens in Palestine, so it all depends actually on specific agendas.

>RHN: Who is funding most of the health research?

JJ: Canada’s International Development Research Centre [IDRC] is very interested. And we have a major research institution here, the Birzeit University Institute for Community and Public Health. And there are other research centres such as the Palestinian Central Bureau of Statistics, a governmental body. The Ford Foundation is interested in research. And the Italian Cooperation sometimes funds research initiatives.

>RHN: So the question is will these people listen to this report?

JJ: This is what we seek with IDRC – we want to put pressure on funders to fund these proposals. But it is a problem in Palestine, I think, that this research has been submitted to the Minister of Health, and all the people concerned in the Ministry of Health, but sometimes the funders come through to a certain key person who doesn’t participate [with the ministry], and since there is no systematic mechanism, research is duplicated.

>RHN: So your conclusions need to be quite widely distributed amongst all those who have an influence on research in Palestine?

JJ: Hopefully, yes. We have distributed it to everyone, basically to all who participated, but we didn’t do a dissemination plan for any more than this.

>RHN: But if IDRC is one of the major donors and you’re talking with them, that’s a good move?

JJ: Yes, but actually it’s also partly funding this research [so it was expected].
RHN: You consulted with the researchers, and you’re a researcher yourself. Are researchers as a body, convinced by these proposals?

JJ: Yes. They are.

RHN: And they would like to do this work?

JJ: Yes.

RHN: That’s very interesting too, because another factor in research, of course, as I’m sure you know, is that it’s often (and inevitably) driven by academic priorities, and academic career-making, and getting your publications in the right journals, and so on – and it doesn’t necessarily relate to the real world outside.

JJ: Yes, but the thing is, this was discussed between researchers and policymakers from all areas and from the government, so this was an interesting discussion.

RHN: I guess the researchers have to be sure that they can make a career out of this, as well?

JJ: Yes, but I think these proposals respond to the actual needs, even of research in Palestine – because it responds to the priorities, and what we need.

RHN: Of the whole country?

JJ: Yes, and for the policy aspects – we need research for this.

RHN: Is there anything else you would like to stress about your specific conclusions?

JJ: The thing is, and this is a pessimistic aspect, because people who are stakeholders in health are involved in day-to-day operations, emergencies, and humanitarian aspects, they tend to forget the policy, and long-term planning for the health sector, and the development aspects. This is why we have the problem in Palestine that we didn’t have a development plan until now, and we didn’t work on policy issues.

We have been discussing these issues for years, and these questions, and policy and research aspects, are not new to stakeholders, but unfortunately, because of the situation internally, and due to the occupation, we haven’t been taking a strategic view on the development of the health sectors. We’ve been focusing on our day-to-day operations.

RHN: Just living from moment to moment.

JJ: Yes, and this is bad.

RHN: But it’s rather forced on you by your situation.

JJ: Yes, but we need to think strategically, as well, we really need to take this into consideration.

RHN: Do you want to say anything about your actual, specific conclusions about what research is needed, and for example, on health insurance, and so on?

JJ: Yes. I think we need to revise the current health insurance system because this hasn’t been changed, due to the political situation and the emergency. Health insurance is covering around 80% of the population. This has been overloading the Ministry of Health, and the financial system – and I think we need to revise this, and [to research] what kind of systems we need to develop.

This also links to the tertiary services needed on a national level, and to revise this... A lot of financial resources are going to refer patients abroad, even under the health insurance, so we need to revise this in terms of health financing.

In human resources we need to see what exists in the market and plan our educational programme based on this and develop incentive plans and licensing systems, because these are important in Palestine. But all of the non-state sectors, because we have successful pilot experiences in cooperation we need to develop this and probably think about more partnership between the government and the private sector.

RHN: I would say that you’ve also got many lessons here, which are exportable. That’s to say, it would be great if other countries could do the same thing you’ve done; although, of course, not being in the same kind of situation of civil society involvement in health that we discussed it may be more difficult. Nevertheless, have you thought about how you can advise other countries on how to conduct this kind of study?

JJ: I have been thinking with Fadi El-Jardali on how to take this further. We have been discussing experiences with researchers from other countries, so this has been the sharing that we’ve had, but we didn’t think further about that aspect.
Setting research agendas in the Middle-East and North Africa

The Palestine study was only one of a forthcoming series of nine country reports in addition to a comprehensive regional report. The Principal Investigator tells RealHealthNews what he’s learned.

Focusing on three questions of immediate interest to policy makers (ministries of health, finance, and so on) and key stakeholders, a series of Middle East and North Africa (MENA) studies on health systems research priorities is seeking wide national consultations to set agendas for national research into health financing, human resources for health, and the role of the non-state health sector in nine low and middle-income countries: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, Syria, Tunisia and Yemen. This is the first regional priority setting exercise conducted in the MENA region.

Here we asked the Principal Investigator for the whole group of MENA studies, Fadi El-Jardali of the American University of Beirut, Lebanon, to tell us more about the regional study’s concept and process.

> RHN: What’s your view of the Palestine study that was just completed?

FADI EL-JARDALI: Palestine is a very good example of a non-state society that’s very active in conducting some work of relevance to policy, in the hope that they will be able to change and influence those policies, in a state that is weakened by internal conflict.

> RHN: But if the state is weak, aren’t the policies of NGOs and other actors in health also relevant, as much as the state’s?

FE-J: Absolutely – where the capacity of the state to conduct research and make evidence-based decisions is a little bit lacking. Health officials are interested in making evidence informed decisions; however, it is sometimes difficult for them to support health research when there are more pressing issues to deal with. This is in addition to the lack of funding allocated for research.

If you look at the whole region, at how much ministries of health are dedicating to research out of their health budgets, it’s less than 1%. Which is nothing! The region has the second lowest proportion of scientific publications addressing health systems topics in the world (0.8% among all WHO regions); the lowest rate is in Africa (0.6%).

While health research funding is insufficient in the nine countries in our study, available funding goes mostly to operational and action research – due to limited time and funding. And doing research in a ‘quick and dirty’ way can compromise the quality of generated evidence and its uptake by policy makers. So we at the university and other academic researchers heavily depend on external funding. Without that we can’t do much good research. For example we couldn’t have done the MENA studies themselves without the support of the Alliance for Health Policy and Systems Research and the additional funding received from the International Development and Research Centre.

> RHN: So to whom are the MENA studies addressed? If the governments are weak and uninterested in research, and the real funding comes from donors, shouldn’t they be addressed to those donors?

FE-J: Yes, but the key informants we met – politicians and policy-makers and key decision-takers in the government and non-state sector – were very pleased that for the first time health systems researchers were listening to their opinions about research priorities and the next steps. They very much appreciated that.

> RHN: So you might actually see the percentages allocated for health research go up, if the research you propose is relevant to their needs.

FE-J: Exactly. And this is the point that they made. They said to us that if you go and do policy relevant research on the things that are of priority to us, definitely we are going to consume your research evidence – to help us make evidence informed decisions. But they also emphasized that donor funding should be more responsive and supportive of national and regional health research priority needs.

They said three things. First, they want our research to be a little bit more policy-relevant. Second, they want local researchers in their country to do studies that are specific to their national context – so their capacity to do such research is important. They don’t trust international evidence to solve their country specific health systems problems!

And the third request was that they really want us to disseminate those results to them in a very user-friendly manner. They
just want to understand the main findings, to help them make better decisions based on evidence.

So I think there is a huge opportunity now in the Middle East – evidence-based policy has become a big buzzword. Policymakers acknowledge the importance of evidence, they want to make decisions based upon it, but they want national researchers to do the work, in their own context. So the next step is who’s going to fund the research priorities that were identified in their countries, because national pockets in developing countries are small, particularly when it comes to research.

“All the countries in our study want to make the health system more equitable, to meet needs and protect the underprivileged and poor populations from catastrophic health expenditures.”
FADI EL-JARDALI

This is a challenge – because if we make new research proposals, based on the research priorities identified by them, and we don’t get funding for it – they are not going to trust us again. Our regional research has created momentum and raised expectations, and we need to deliver accordingly. That is why we need the support of donor agencies.

>RHN: So you are addressing that question to donors?
FE-J: Absolutely. We hope that the donors can really take this seriously. If they really want to help those countries improve their health care systems, both at the policy and delivery level, we need to build capacity and funding to conduct context-specific research that address the questions that were raised by policy makers.

Otherwise we are just telling the policy-makers yes, thank you for your time and suggestions, you told us what you want, and goodbye!

You know the health budget in the low and middle-income countries is the Middle East is very small. And the priorities of the governments are not always in health. We have to acknowledge that. In light of pressing challenges, health research can fall between the cracks. So we need to have health research that really addresses policy-makers’ questions.

>RHN: So let’s have a couple of examples. What kinds of question have come up, and what can research do about them?
FE-J: For instance, many of the countries are really struggling with social health insurance. All the countries in our study want to make the health system more equitable, to meet needs and protect the underprivileged and poor populations from catastrophic health expenditures and so on.

>RHN: And they hope to do this with social insurance?
FE-J: Exactly. But they are struggling to choose the best model to experiment with, without much risk, to cover a larger population but with the existing resources.

>RHN: That question is likely to be a very local, cultural matter, isn’t it?
FE-J: It is. And another example is human resources for health. Many countries are really losing their competent and qualified health workforce to other developed countries – either in the Gulf, to the oil-rich countries, or to Europe or North America.

So they want to know how they can create a good incentive mechanism, and retention strategies, to help us retain their competent and qualified workforce and how can they address their shortages and mal-distribution problems.

Also they have no human resources planning. So they want to know how much and what type of human resources they will need 10 years from now. They also want to know how they can improve their academic educational programs to better meet the needs of their country.

As for the non-state sector, all countries agree that this sector has a substantial role in helping meet health systems goals. However, the sector is poorly regulated and coordinated by the state. Policy makers would like to know about the foundational elements for building a strong and well functioning public-private partnerships. They would like to find ways to optimize the use of existing resources of the non-state sector, to reduce duplications, and to develop methods to monitor and evaluate their contribution including service provision and performance.

These are some of the questions that came from almost all the countries – and they want answers to them! ■
Health systems

Palestine's practical research priorities

A new study [see previous articles] has identified a whole series of research priorities for improving health policy and delivery. Most of them could be translated to the needs of ministries of health in any developing country. Here is a selection:

- How can the Ministry of Health [MoH] improve the current structure of the Governmental Health Insurance [GHI] Department?
- How can the MoH improve the demand-side incentives for efficient health care use in the current GHI system?
- What are the current models of health insurance systems employed in Palestine by the various health care providers (governmental, NGO, private and United Nations Relief and Works Agency [UNRWA])? How successful are these models and what are their advantages and disadvantages?
- What are the types and costing systems of the existing health services provided by the four health care providers (governmental, NGO, private and UNRWA)?
- What are the opinions of citizens/consumers of health care services about the implementation of a compulsory health insurance system in Palestine?
- What type of national health insurance system is feasible for implementation in Palestine?
- What are the possibilities of implementing a ‘mutuality health system’ in Palestine, as used in countries like Tunisia, Morocco and France?
- What are the possibilities for creating an independent national health insurance fund?
- What types of national tertiary care and services exist in Palestine?
- What are the mechanisms to improve the current national tertiary system in Palestine?
- What new tertiary services are needed on a national level?
- On what type of tertiary services is the referral system currently spending its most financial resources?
- What are the human resources for health [HRH] needs in Palestine?
- How to target shortages in HRH?
- What is the role of the unions and professional bodies in HRH management?
- What type of national database on HRH management is needed for Palestine?
- What is the satisfaction of citizens regarding the performance of health professionals?
- What types of licensure and accreditation systems are needed for health professionals?
- What are the existing educational programs for HRH and how can these be used to fill gaps in other programs?
- What are the HRH needs in Palestine and do the existing programs correspond to an actual need?
- How can in-service training be implemented to include specialization scholarships?
- What type of programs can be implemented in the public sector for newly graduated HRH?
- What type of national Continuous Education System do we need for HRH in Palestine?
- How can a model “teaching hospital” be created?
- How performance quality of health professionals be monitored?
- What gender policies are needed for women that elicit their positive role in health?
- What is the role of health workers in health and in community outreach and how to improve their functions?
- What are the mechanisms to raise public awareness regarding the importance of midwifery and their role in society on a national level?
- What are the lessons learnt, advantages and disadvantages of the existing partnership models among the various health care providers?
- What are the best mechanisms to support the national health policy and strategic planning committee?
- What are the types of services, roles and coordination mechanisms of all non-state sectors in the present health system?
- What terms of reference and work plans are needed for the Private Hospital Forum in the West Bank?
- What mechanisms and policy priorities would enhance the capacity of the NGO coalition?
- What types of contractual agreements are needed among private, public and NGO sectors?
- How to develop a national Monitoring and Evaluation framework for the Palestinian health sector? What are the process and indicators needed?
- What Annual Performance Review process is needed for the health sector?
- How can a national central library for the health sector be created? Who should be responsible for its creation and maintenance? How to ensure its continuity and sustainability? How can research papers be used in policy analysis?
Community volunteers – unpaid or very poorly paid local workers from the villages and slums of developing countries – are proving increasingly valuable to many health, water and agricultural programmes. They know their own people, and they know how to help them.

But as this gets more widely known, programmes using them are beginning to overlap, some in the same villages and some even with the same volunteers – while there is no coherent policy for how “use” or to reward them.

In any industry, this would be called exploitation – but because it is aid, the issue is being conveniently ignored. It’s not only unfair, it’s a waste of a resource, and a recipe for disaster as demands and expectations of these people increase.

Community volunteers can do great things. In a recent issue, we reported a study supported by the Programme for Research and Training on Tropical Diseases (TDR) and the African Programme for Onchocerciasis Control (APOC) – see READ ON, Drug distribution: trust the people – which indicated that allowing communities to make their own choice of unpaid volunteers for the distribution of ivermectin tablets for onchocerciasis could also double provision of malaria treatments, bed nets and vitamin A, and improve TB diagnosis.

Now another APOC report on payment of volunteers [APOC relies on community choice of volunteers, and their goodwill] is showing that the use of community volunteers is rife among health programmes, and in programmes dealing with water, agriculture and the environment, and that some pay and some don’t, and in a wide variety of ways and levels.

As a result, there is emerging across the whole world of development a great potential resource for evidence of what makes for success among community volunteers – if only it were scientifically studied and compared. But also looming is the potential for the deep confusion, disillusionment and even abuse of volunteers.

RealHealthNews says it’s time for cross-programme, multi-agency, coherent research on what works best – both for programmes and for the volunteers themselves – and the creation of an evidence-based, joint policy on how these volunteers should be selected, employed – and, if they wish – rewarded for their work.

In this way a tremendous potential resource for development, one that could even define development itself – the capacity and energy of the very people in need – could be created across the whole field of development.

Multiple health programmes – as many as 68 in Nigeria alone – are using unpaid or low-paid community volunteers, and other sectors such as environment, water and agriculture are doing the same. A new study of reimbursement of health volunteers is revealing the need for an internationally agreed strategy.
Community of authors

Authors of the community volunteers report are:

- Michelle J.S. Remme, HIV/AIDS, gender and food security officer, FAO Malawi
- Elizabeth Elhassan, Country Representative, Sight Savers International, Kaduna, Nigeria
- Uwemedimo F. Ekpo, Data Analyst and Parasitologist, Department of Biological Sciences, University of Agriculture, Abeokuta, Nigeria
- Hajia W. Giwa, Director Communications and Essential Services, National Programme on Immunization (NPI), Abuja, Nigeria
- Zakariaou Njoumemi, Health Economist at Health Economics Research and Evaluation Group (HEREG), Yaounde, Cameroon
- Obiona Nwaorgu, Researcher, Department of Parasitology and Entomology, Nnamdi Azikiwe University, Awka, Anambra State, Nigeria
- Frederick O. Oshiname, Researcher and Lecturer, Department of Health Promotion & Education, College of Medicine, Ibadan, Nigeria
- Kabali A. Turinde, Kabali Asaph TURINDE, Community Health Specialist, Makerere Institute of Social Research, P.O. Box 16022, Kampala, Uganda
- Kora G. Tushune, Health Economist, Jimma University, Jimma, Ethiopia
- Mahmud M. Zubairu, Zonal Coordinator, National Programme on Immunization (NPI), Abuja, Nigeria

“Where such a policy exists, it tends to prescribe the provision of EMI” (ie to demand it), the authors say. “The Ethiopian Ministry of Water is the only ministry in the study to have a general policy to not give EMI. This lack of guidance goes a long way in explaining the lack of harmonisation on the issue. Moreover, where a general policy exists it tends to be rather generic, without specific parameters for standardisation.”

“Most health programmes have a policy/practice of giving external monetary incentives,” the report says. “Only the national data of Nigeria and Uganda contradict this, with less than half of programmes that use community volunteers, having a policy/practice to give EMI. At sub-national level, the reality is that programmes with a policy/practice to give EMI are by far the majority (approximately four out of five).

“The two major reasons reported for giving EMI are to motivate volunteers and to facilitate service delivery. The main reason not to give EMI is to ensure sustainability.

“Cash incentives are the most common types of external monetary incentives (excluding low cost in-kind incentives like T-shirts, caps, refreshments, etc). Transport allowances, stipends and per diems are typical forms of EMI and they often represent a sizeable income, especially when compared to GDP per capita.

“The average monetary value of EMI varies per site (from US$ 20 to US$ 310 per volunteer per year) and per health issue (from US$ 10 to US$ 290 per volunteer per year). TB/Leprosy, Reproductive health, STI/HIV/AIDS, Malaria, Nutrition and Immunisation are the health issues providing the highest EMI. These also happen to be the issues receiving the largest donor funds.

“Donors play a significant role in setting these EMI. Their role is mostly indirect, through the provision of funds. Yet some donors appear to be influencing policies more directly by actually convincing programme managers to have a certain policy or by making it a funding condition.

“Current geographical overlap is high, with an average of 10 programmes overlapping per district. And this number is only likely to increase. The financial cost of these EMI to the health systems is considerable” the authors find.

“The occurrence of using the same community volunteers between programmes is highly variable. Where it is done, it could have the positive effect of alleviating some issues, especially if programmes that share volunteers also have a concomitant joint policy on EMI. However, this is not yet the case and where sharing is common, providing programme-specific EMI remains equally common.

“All in all, coordination and mostly harmonisation are very limited. Where reported, harmonisation remains incomplete, as is the case in Cameroon, where programmes continue to provide their own incentives funded out of their own baskets.

“The study suggests that there is a need to formulate a general policy at the national level to guide the implementation of the widespread practice of giving EMI to community volunteers” the authors conclude.

“The current fragmentation of incentive packages is neither cost-effective nor a fine example of coordination in the health sector” they say.

This research needs to be carried through into a second phase, the authors say, “to determine whether the policies identified here are reflected in practice, among the communities and community health workers themselves.”

This second phase is currently part of TDR’s business plan for 2008-2013. Concrete activities will be decided during the first meeting of the TDR Scientific Advisory Committee in May 2008, Michelle Remme told RealHealthNews.
WHO research strategy aims for leadership

A year into the two-year gestation of WHO’s research strategy, some striking outlines are beginning to appear

**INTERVIEW WITH ROBERT TERRY**

**SUMMARY** • The WHO research strategy team has just finished its global consultations, in a democratic approach to setting a new focus and role for WHO in health research: leadership and convening power to help other bodies set agendas, and an internal focus on ‘making a difference’ – getting care to where it’s most needed. RealHealthNews talked to team leader Robert Terry.

ROBERT TERRY: In 2007 in Resolution 60.15, the WHA requested the Director-General to submit to the 62nd WHA in 2009, a strategy for the management of research activities within WHO. That’s the mandate.

So we’ve been doing a lot of regional consultations at WHO offices, talking to a lot of stakeholders, and to summarise, a general feeling is that there’s a lack of coherence in WHO’s work in and around health research.

RHN: I think what our readers would like to know at this point is how far you’ve got towards building a coherent strategy – and whether you are forming a view already on what impact that strategy might be likely to have, and on whom.

RT: Well we tried to make this process as participatory as possible; and I actually think that’s unusual for WHO. I’m new to the organization – I previously worked at the Wellcome Trust in the UK. The standard approach [at WHO] appeared to be that good people in Geneva work very hard, produce great ideas, analysis and reports and then others comment upon them.

But what we’ve done here is to start the other way around. We’ve been organizing meetings in every single regional office, bringing in the country representatives, and talking to the Regional Advisory Committees on Health Research. We’ve just finished that process.

So we’ve had meetings in all six regions. We’ve also spoken to more than 100 stakeholders on a one-to-one basis, drawn from right across the spectrum of the type of people that WHO needs to work with – so that’s ministries of health, funding agencies, and leading researchers and commentators on health research globally.

We’ve also just had a meeting of the global WHO Advisory Committee on Health Research, and the point we’ve got to is that we’re just starting to pull all that together.

RHN: You must have quite a pot-pourri of ideas!

RT: It’s a lot of ideas. We do have some working documents, but they are not at the stage when it could be circulated widely. I find that once people start talking about drafts they forget clever ideas and focus on details and definitions.

RHN: What impact do you expect or hope for in the end, when the strategy is finalised and in use?

RT: The strategy will need to have an impact both internally, within the WHO organization, to move us towards leadership in health research rather than that lack of focus that people perceive, so we’ll need a real emphasis on trying to change the internal culture; and externally, positioning WHO in its global leadership role in health research.

Some people say it’s abdicated that leadership in the last maybe ten years, allowing other organizations to enter onto the scene, like the Global Forum for Health Research and COHRED [the Council for Health Research and Development].

RHN: Are we talking about bodies like the Gates Foundation?

“The standard approach [at WHO] appeared to be that good people in Geneva work very hard, produce great ideas, analysis and reports and then others comment upon them. We are starting the other way around.”

ROBERT TERRY

Continued on page 12 >
best ideas, at every level and globally about these issues.

RT: Exactly. That's the leadership. And that's where the research strategy, I would suggest, has gone a bit further than just moving the tables and chairs around within the organization. It will redefine what WHO does at global scale.

The WHO research strategy is not the global health research strategy. But it is a strategy which positions the WHO to lead, facilitate, convene, all those things, on a 'global agenda'. And the reason I say 'global agenda' is that it's easier than saying in all countries at all levels etc. etc.

RHN: I would say it has a particular role in bringing the voice of the South to bear.

RT: Well we hear lots and lots of perspectives, and certainly one of those is that WHO should have a focus on one part of the health research strategy – that it should be promoting research that has the largest amount of impact on public health needs as identified by the countries.

Where we've got to at the moment is that we've that kind of big vision, and four or five major goals. One will be around how we actually promote health research to address public health needs; another will be towards ensuring strong, transparent and sustainable national health research systems; and another will be promoting best practice in health research.

A fourth might be called ‘lost in translation’, why when we’ve got all this research, all these ideas, that we’re challenged in getting it to make a difference, translating it into policy that has an impact.

A fifth would be ‘making it happen’ – making the changes in WHO so it can deliver those sorts of things.

RHN: What about the independence of existing programmes? Quite a lot of health research is done either within or in close association with WHO already, and it’s run rather independently – for example the Tropical Disease Research Programme (TDR), the Human Reproduction Programme, (HRP), and programmes like the new Alliance for Health Policy and Systems Research; these programmes have their own well-established ways of setting programmes and policies. Is it foreseen that the WHO strategy will either influence or even control the policies of these bodies?

RT: I wouldn’t say control, but yes it will have to influence them. And yes it will have to provide some sort of coherence to what are called the ‘special programmes’. Everyone talks about the high-profile ones, the ones you just mentioned, but there are more than 20 or so departments who have research as a big part of what they do.

Some of it's the classic research, like TDR – primary research and research generation and those sorts of things; others have to do with normative work and setting standards – finding out what is best practice in a field, like health systems research – it’s changing things incrementally, doing meta-analysis, producing guidelines. Now the research strategy would also encompass that activity. It's public health research that's so lacking.

A lot of Gates and other funding goes towards looking for the silver bullet, the cure for AIDS or malaria and so on; but much less of the funds go towards what we would call 'making the difference' – how do you actually deliver this stuff? Why is it that bednets are used in so many different ways other than stopping mosquitoes biting children? – that kind of social, behavioural, economic and other multi-sectoral stuff.

It's not sexy; but that's the sort of stuff that WHO can do.
It's evidence time for primary health care

WHO ADG Carissa Etienne calls for a systematic review of all primary health care research

SUMMARY • Carissa Etienne, WHO ADG for health systems, stresses the need for evidence, information and research to make cost-effective health policies in developing countries. Specifically, and with passion, she calls for a systematic review of all research on primary health care since Alma Ata to provide real evidence on what works and fails. Community health workers should also be studied, she says – all against a measure of health outcomes.

›RHN: In your career as Chief Medical Officer of Dominica in the Caribbean, then as Assistant Director of PAHO, and now as Assistant Director-General for Health Systems and Services of WHO in Geneva, you’ve shown yourself very concerned with evidence. Can you tell us why?

CARISSA ETIENNE: In the Caribbean and in our interaction with other countries I have seen us make the same mistakes over and over again. And I have seen us make interventions that have not been evidenced-based, and we haven’t had the outcome we had hoped for. And for me outcomes are very important, because they mean how do we affect the quality of life of those who are poor, marginalised and vulnerable.

Most of us have started with very good intentions, but without evidence we can become very ineffective and inefficient.

›RHN: Could you give us a couple of examples? What mistakes have been made again and again, without evidence?

CE: Well certainly: you know when I worked in PAHO we insisted on having all of the information before making decisions or taking action, and our technical divisions were the ones responsible for getting that evidence.

A lot of health research is done about developing countries, and particularly research that takes place in developing countries, but a lot of that is really made by researchers in the North; and sometimes they don’t have adequate focus on the local problems – or an understanding of the local situation.

Hence the analysis of that research and the conclusions sometimes do not speak to the realities of the local level.

So how can we help developing countries to create an information system that yields the data that is needed for planning and decision making? And at the same time how do we help them build capacity to define their research needs – and conduct it themselves?

›RHN: Did you come to these views early, in Dominica, or from your international experience?

CE: This is an emerging view, based on my experiences in the Caribbean but also significantly in PAHO as well. In PAHO at our governing body meetings, ministers are often saying ‘we need a health information system, so we have the appropriate information at the appropriate time, when we need it to make a decision! When are you going to help us do that?’ That is what they say.

›RHN: So what kind of evidence have you been able to find and use, in your experience, that actually has been useful to you? Have you found anything that’s been appropriate?

CE: Well certainly: you know when I worked in PAHO we insisted on having all of the information before making decisions or taking action, and our technical divisions were the ones responsible for getting that evidence.

Take blood donations, for example – the evidence that blood from paid donors has a higher risk of being infective, than if you take it from voluntary unpaid donors. That was very important for the management of blood banks.

Even in health systems, the gathering of data that shows that families can be totally impoverished by trying to gain access to health services [catastrophic health expenditures] – that was also an important piece of information.
And in the Americas, studies showing how the fragmentation of health services was having an effect on the health and welfare of different segments of the population—they were significant.

>RHN: What’s your vision for the Health Systems and Services cluster in WHO? What role do you think research and evidence will play in it?

CE: I often say that because I’m a team leader, par excellence, I don’t like to speak about my own vision! I like to speak of the process to develop a collective vision. That’s very important.

But the Director-General, Margaret Chan, has enunciated her own vision—utilizing the primary health care approach for health system strengthening, and I think that my remit, and within the cluster, is how do we build within the health systems framework an emphasis on the key building blocks of the primary health care approach?

And for primary health care we are not merely referring to the first level of care, but to a strategy that embodies equity and rights and solidarity—that speaks to all of the elements of the primary health care strategy.

>RHN: It means looking at the health system from the point of view of the poorest and most remote user.

CE: Yes, but also the city dweller and whatever makes somebody marginalised. It is not merely for poor countries—it’s also relevant for developed countries...

>RHN: Where there are immense health inequities, even in a rich economy like the United States, for example...

CE: Exactly. So how do they look through the lens of equity, and organize a health system that recognizes there is a private sector as an important player, that we are building a health system within a health sector, but also that that health sector interacts with so many other sectors?

>RHN: I was struck that the DG enunciates a ‘2X2X2’ approach in which one of the twos combines both health systems and research. She said that these two were strategic: “Capacity building—particularly strengthening health systems—and information and knowledge. Here I mean getting the evidence right and setting the agenda for research and development.” So she combines health systems and research in one strategic bundle.

CE: And I think it’s important, now we are on this new course of primary health care, that we are at the point where the sceptics are asking ‘did it work?’

“And for primary health care we are not merely referring to the first level of care, but to a strategy that embodies equity and rights and solidarity—that speaks to all of the elements of the primary health care strategy.”

CARISSA ETIENNE

>RHN: You mean going back to Alma Ata and what happened after that?

CE: Exactly. Is there any evidence that there were benefits and that it can be sustained? Do you have evidence of what worked and what did not work?

Evidence exists, but we really have to apply some rigour in really looking to find all the research that has been done [on this] and to pull it together, to categorise it. I think we are past the time when we can just say ‘Of course it works! There are countries with good experiences!’

We ourselves, at WHO, need to be able to tell our member states ‘this is the evidence’.

>RHN: That’s very interesting—so you think it’s going to be valuable, you think, to do a systematic review of all the evidence on primary health care?

CE: Yes. I think so. So our members can make informed decisions towards primary health care, where they want to go.

I think it’s true that the Secretariat is in very much of a listening mode as far as that is concerned, listening to what member states are saying and what they are calling for.

>RHN: In relation to primary health care?

CE: Yes. And to health systems strengthening and their concepts of the primary health care approach. We think it’s going to be country-specific.

>RHN: Well of course the WHO does have to listen to its member states; it’s essentially a tool of the member states...

CE: Yes, yes...

>RHN: ...but it also has a great deal of expertise at the centre, and in the regions, and in the country offices, and among its many many expert groups; so it always seems a bit disingenuous to me when people say they have to defer entirely to the countries!

CE: No, no, and I think we’d be reneging on our responsibilities to defer entirely to countries; I think we will need to continue to work in terms of providing options, recognizing that the realities in our countries are different.

So we will have to prepare a menu of options, so when we sit with country X, we can say, look, for your particular situation and needs, we think these are the options, and these the advantages and disadvantages.

>RHN: Furthermore I guess the bottom line regarding evidence, for primary health care, is that WHO has got to be prepared to hear what it might consider the ‘wrong message’: so if you learn from your systematic reviews that primary health care did not work, or was not cost-effective or whatever, would you listen to that lesson?

CE: Yes. And the follow-up question would be why, why didn’t it work? When I hear ‘it didn’t work’ the next thing I say is what is ‘it’? Because frankly the world did not implement the Alma Ata concept. It relegated it to care for the very poor and very rural.

But inherent in the primary health care declaration of Alma Ata was also this higher concept of ‘health development’, and development in general, which says
that equity is important, that it must be a multisectional approach, that your policies that you pass on health even at the highest national level have an impact on health and well-being. That part of it was definitely ignored.

>RHN: How strong do you think health system evidence has to be? It’s not like physics, is it, or even a clinical trial; what constitutes for you good evidence in relation to health system strengthening, or indeed primary health care?

CE: I certainly would like to see what service delivery models have been beneficial in terms of integrating care in terms of the impact on mortality, morbidity and quality of life.

>RHN: You want to measure health outcomes in relation to different kinds of health system structure.

CE: Yes. Then putting this evidence, and letting countries decide. It’s always their decisions. I would like to see it terms of skills mix, what has been the impact of using different categories of health care workers. What have community health workers contributed to health and well-being?

>RHN: Indeed. And they are being very widely used – we have a report in this issue of RealHealthNews [page 9] in which it’s said that in Nigeria alone 68 different federal health programmes are using these workers, and programmes outside the health sector too. I would agree with you that we urgently need to study how that works!

CE: And in terms of your scarce funding and workforce – how best to organize that workforce? If you spend the money on specialists, what impact does that have on general health and well-being? If you spend it on a greater skills mix, what is the outcome?

I think in my heart I know the answer, but I should not depend on my gut feeling!

>RHN: Yes we’ve all got anecdotal experiences that we can bring to bear on these things but you need research to determine what is generalisable and what really works.

CE: Exactly. Many countries are at the point where they feel that they are spending a lot on health – although the evidence does not show that – and that they are not getting the outcomes that they are expecting.

So we have to be able to help them make those decisions.

>RHN: A lot of these questions need local answers – these studies need to be done everywhere, don’t they?

CE: Yes I think so. Our Alliance for Health Policy and Systems Research working with clusters in WHO did some policy-maker interviews in some 24 countries, asking for their needs for evidence, and their knowledge gaps. We did this for health financing, the role of the non-state sector, and human resources, and we are already beginning to have a feel for what some of those knowledge gaps are.

>RHN: So there are some general questions that everyone is asking.

CE: Yes. Governments want to know the implications of universal coverage in different settings. And what is the acceptability of different methods to households. How best should they design universal coverage schemes?

>RHN: We report in this issue on studies in Palestine and other low and middle income countries in the Middle East and North Africa, asking governments and politicians and health professionals and civil society the question, what research do they need to improve health delivery, and the result is a long series of extremely practical questions.

CE: Exactly. They are struggling and we have to help them find answers!
Health systems

Vaccine fund spending US$ 500m on ‘innovative’ health systems

29 nations approved for projects which should have spin-off for countries’ whole health programmes

INTERVIEW WITH CRAIG BURGESS

SUMMARY • The US$ multi-billion-a-year GAVI Alliance is spending a fraction of its budget to help its vaccines get to the end of the track, by strengthening health systems in a group of countries in central America, Africa and Asia. But what does it mean by ‘innovative’? Does that mean science?

It may be counter-intuitive to see a big vaccination funding programme like the GAVI Alliance [formerly the Global Alliance for Vaccines and Immunisation] supporting health system strengthening – because the classic model for the vaccine preventable diseases is to have separate, vertical programmes, sometimes even with the vaccinators flying in from abroad.

But GAVI is different: it provides support directly to country governments, not through other agencies. Also its large budget and global nature encourages vaccine manufacturers to take a positive view of developing country markets – and thus add relevant, affordable products to their portfolios.

Moreover, GAVI is evidence-based, so RealHealthNews asked Craig Burgess, responsible for the GAVI health system strengthening programme – which purports to embrace ‘innovation’ in health systems – to tell us more.

CRAIG BURGESS: Well just as a backdrop, health system strengthening is not new – you could say that primary healthcare is a large part of health system strengthening: it means having a more holistic view of health and the delivery of healthcare packages.

GAVI Phase One, 2000-5, was really highlighting the introduction of new vaccines [such as Hepatitis B and the Haemophilus influenzae b vaccine], and increasing immunisation coverage, mainly focusing on DTP 3 [diphtheria-tetanus-pertussis] vaccine.

But there was a study done in 2004, commissioned by GAVI, through Norad [the Norwegian aid agency], which looked at the main barriers to the increasing coverage in a sustainable manner.

RHN: This was done by academics?

CB: By a group that was commissioned by Norad. They looked at the main barriers to increasing immunisation – but there were no surprises.

Basically, they came up with issues that were broader and wider than the immunisation programme alone. They include human resources and motivation, transport, fund flow issues to peripheral level, management processes especially at district level and below, infrastructure, etc. etc. – there is a whole range of problems.

So it was felt that as GAVI increases its portfolio of relatively or more expensive new vaccines, such as rotavirus and pneumococcus and Hib to certain extent, and others, to protect that investment we need to make sure we contribute to [health system strengthening].

It’s no longer good enough just to make sure the vaccines are available at the Ministry of Health’s door. There’s a whole range of barriers between the Ministry of Health’s door and the kid’s arm or leg, as the case may be. So we’re looking at ways in which we can overcome some of those.

So in 2005 a group of people in the secretariat and also partners drafted an investment case for the GAVI Board to look at an investment of US$ 800 million for the 72 GAVI countries eligible for our funding, to overcome some of these health system barriers.

Now initially, the Board felt it was a controversial decision, because some members felt it was a bit of ‘mission creep’ and importantly that it was hard to measure impact and monitor attribution – because you’re in a broader range of activities. It’s not as precise as just measuring DTP3 immunisation coverage – there’s a whole range of other indicators needed.

But having said that, other Board members really want it recognised that overcoming health systems barriers is an important aspect of delivering vaccines and other child healthcare packages. So on the basis of that, an investment case was approved for US$ 500 million, between now and 2015.

The vision is until 2015, but countries can apply but with the understanding that they will be evaluated in 2009, and again in 2012 to look at process and impact as well.

So since then, US$ 500 million has been made available; countries are to identify
the key health system bottlenecks or barriers to delivering immunisation, and come up with a proposal that has to be linked to their national health plans, so they can’t be stand alone projects: they have got to be aligned to harmonise with the national health plan.

>RHN: When you say countries, you mean you expect the governments to apply?

CB: The government. We deal with sovereign nations, so the minister of finance, the minister of health has to sign off on the proposal, but having said that, it’s a group of partners at country level who coordinate and help draft, implement, and monitor proposals.

So they submit proposals to the GAVI secretariat, and an independent review committee reviews whether it’s a robust proposal or not, whether it fits into the objectives of overall health in that country and indeed whether it helps or is implemental to overcome some of the health system barriers to delivering immunisation and vaccinations.

>RHN: I’d like to know a bit more about exactly whom the partners are. I guess it varies from government to government. What kind of people are they, what kind of institutions? And secondly, this word ‘innovative’, which you use in your documentation on health system strengthening, what do you mean by that, and what makes a proposal innovative?

>“It’s no longer good enough just to make sure the vaccines are available at the Ministry of Health’s door. There’s a whole range of barriers between the Ministry of Health’s door and the kid’s arm or leg.”

CRAIG BURGESS

CB: First of all the partners are the GAVI alliance partners that you’ll see on our website – basically a reflection of Board membership at country level. It’s individuals, UNICEF, the World Bank, bilateral donors, civil society, and their representatives in developing country, plus the private sector – they are all part and parcel.

>RHN: So it’s the people already on Board in GAVI?

CB: Yes, but it may well include those that are involved with immunisation and child healthcare at country level. It’s a health sector planning committee at national level.

>RHN: So these would be composed of what kind of people?

CB: For the technical component, this is technical groups that know quite a bit about immunisation and planning, but ratifying and signing off on the proposals, it would be the representatives of offices, for example.

>RHN: Let me explain the background to my question. RealHealthNews is about the connections between research, policy making and action for health for the poorest in developing countries. So through policy, we’re concerned about the relationship between that evidence making process and effective action. So the question that’s occurring to me about your programme is, how strong is the evidence you have for the interventions that you end up funding?

CB: First of all you’re asking about the innovation. What is new about it is that it is getting all partners together around a table speaking about a common objective or goal, which has not necessarily taken place before.

Before, bilaterals would just work bilaterally with the government, so one govern-
ment might have a whole host of partners to deal with. But our approach gets them around one table and looks at one common objective.

Innovation is actually encouraged, by which we mean strengthening actions that are working already – or innovatively looking at ways to reach more children. Finding the hard to reach where they live: how do we reach them, what are the innovative ways of doing that?

>RHN: Does the innovation mean research?

CB: No, not necessarily. Although operational research can be encouraged, innovation is looking at catalysing change as well, changing mindset. We had our Nepali colleague come in January and emphasise new ways of doing things and mindset changes within the government.

>RHN: So bright new ideas basically emerge from those groups?

CB: Or not necessarily wanting to reinvent the wheel, but building also on things that work, reviewing things that work through analysis of the health system bottlenecks and not duplicating what is already being funded; and certainly not displacing any funds that already exist, it should be additional funding as well.

So if you look at the website, look at the guidelines. Principals there are encouraged to look at the guidelines, only ten pages long, but it summarises things quite well.

The other thing you have to bear in mind is that the window for the first funding round only opened in 2006, and we’ve had four rounds since then, so it’s only a year. And what we’re discussing just now is really things on paper, the proposals that have been submitted.

Yet in the space of a year, 40 countries have applied out of the 72, and 29 have been approved out of those 40. And that represents a funding of about US$ 400 million.

>RHN: That’s a lot of money.

CB: It’s a lot of money, but the independent review committee goes to great lengths to ensure that there are direct links between this investment and outcomes, so that is the important thing, the outcomes should be immunisation related.

It’s not like a bucket, although some countries want to put the funding into a pool mechanism, which is allowed, but there should be discrete reporting every year on it and discrete output indicators as well.

I just want to emphasis that it’s only been going about a year and funds have gone to countries since May or June last year. When we talk about implementation, our first record of proper implementation will come around in June this year.

>RHN: So then you’ll begin to see the results in terms of immunisation levels?

CB: No, that’s the issue, because that’s an impact, it’ll take several years to see that and this why people often get frustrated. Countries need long term predictable funding.

>RHN: So the outcome measures will be what in June?

CB: It will be more looking at process indicators, how many cars are being bought, how many people are being trained, much more process indicators.

The impact indicators that we look at are immunisation coverage, under five mortality and numbers of districts achieving certain coverage level. I don’t think we’ll see impact on that directly on this investment for several years yet, so there’s a whole range of activities that need to take place before you can really see impact per say and I think that’s one thing that donors sometimes get frustrated by; they want instant impact and that encourages a short term mentality. What we’re trying to do is get away from that and look at long term planning and long term predictable funding.

>RHN: Is there any concern for thinking about the advantage of doing effective proper academic research on what will work and what doesn’t work in improving health systems? For example, not just monitoring the effectiveness, but also trying to attribute the effectiveness, the changes and indicators to particular interventions, with a proper understanding of evaluation?

CB: There are three things. One is the ongoing monitoring, which is on a yearly basis and countries report on what they have done with the funds, what activities they’ve undertaken.

The second is an evaluation, and that’s being designed this year and will start next year. That will look exactly at some of the aspects of the processes, not necessarily the implementation. The latter will probably happen in 2012 when we really look at what has worked, what hasn’t worked.

And the third is there is an ongoing tracking study, which is looking in real time over the next two years what is happening to money and what is happening to programmes in four to six countries. It will add weight to what is happening, what is working, what is not.

>RHN: Who is doing that and in what countries?

CB: We don’t know yet, because the request for proposals went out and proposals will be selected in two weeks time. It’s relatively early days yet, so the design of that work will be ongoing for the next six to nine months.

>RHN: The design will be in six to nine months, and then how long will the studies take?

CB: Probably a year and a half or so.

>RHN: OK, so time to do the study properly.
**CB:** Yes, but all the information is available on the website and we’re encouraging various bodies including academic institutes to look at the proposals, analyse them, see what’s happening, see what’s not happening, it’s in the public domain so the academic institutes are really encouraged to do so.

**RHN:** And are they applying?

**CB:** Academic institutes? Not actually applying, but the information is there for them if they want to look at some of the proposals.

**RHN:** But can they make proposals to do some of this monitoring and measurement?

**CB:** I thought you meant analysis of proposals, and what is working and what doesn’t work.

**RHN:** Yes, I do. Making an analysis of what interventions are causing what result, effectively.

**CB:** I think that’s more part of the evaluation that will take place in 2012.

**RHN:** So that’s down the line.

**CB:** But I think the tracking study will do part of that, but many of our bilateral donors will be looking at the effectiveness of this in perhaps other shapes and forms and maybe asking groups to do that.

**RHN:** It’s absolutely fascinating, but I do get the impression that it’s not entirely engaged with the scientific community as yet.

**CB:** Through networks, through WHO, through the Alliance for Health Policy Research, there are networks of unfortunately mainly northern-based academic institutes, and that’s the down side of it, it’s the usual suspects, Liverpool, London, Harvard, John Hopkins, etc, etc.

**RHN:** They’re involved with you?

**CB:** They have been involved, but what we’re looking more than anything is actually networks of academic institutes at regional and country level.

**RHN:** Now, you mentioned the Alliance for Healthy Policy and Systems Research, you’re working with them too?

**CB:** Yes, we liaise with them and we contact them and they have attended various meetings as well and we encourage them to apply for requests for proposals.

**RHN:** Do you think there’s going to be spin off from your health system strengthening to the delivery of other health goods?

**CB:** Definitely. I think if you look at the health system barriers to delivering vaccines they’re the same health system barriers as for other child healthcare interventions, so the GAVI synergy is with MDG 4 and 5, addressing some of those barriers. This is a contribution to alleviating some of those health system barriers in a very flexible way.

**RHN:** When you say they are challenges, you say these are question marks that you haven’t decided whether to face or not or you are going to face them?

**CB:** They are very much being faced, and the overlying challenge is working as an alliance. I sit in the secretariat, which is helping to facilitate these processes, but who actually does the work on the ground is a group of partners, so we are an alliance partnership, which includes the multilaterals, the bilateral, etc.

But to try and get consensus in a very complex arena such as health system strengthening is difficult if not impossible, so it’s basically two steps forward, one step back and agreeing on say, the USAID or the Gate’s approach to monitoring, who want a lot more data, as opposed to perhaps the more northern European donors’ viewpoints that we should be more harmonised in the line with countries.

It’s difficult to reconcile that, and that’s often not a technical discussion that’s a political decision, and it’s why quite a few of our papers for options go up to the Board level for a political decision, once we’ve got that green light, they point us in the right direction.

---

**“The impact indicators that we look at are immunisation coverage, under five mortality and numbers of districts achieving certain coverage level.”**

**CRAIG BURGESS**

One thing I didn’t highlight is some of the major challenges – the first of which is monitoring: many Board members and institutions want a lot more information and detail about how money is being spent, and of course that generates a lot more work for countries to report on that. Other Board members and institutions are saying that is not appropriate, we should take an investment approach to it and look at the output only, and view it as an investment and look at what is done in terms of output and impact at a later stage – using not a GAVI specific mechanism but a country specific reporting mechanism.

And the other main challenge is reducing fiduciary risk as well. Do we go down the route of the Global Fund that spends US$30 million on accountancy companies at country level? There’s still frank fraud and there always will be frank fraud and misappropriation of funds, but it’s setting in place the alerting mechanisms that help us investigate appropriately, and take appropriate action.

Those are the two main challenges now, as well as helping support countries, through our partners, to actually implement many of these proposals.
Artemisinin: diversifying the sources

The Artemisinin Enterprise has three strategies to make affordable artemisinin for malaria

SUMMARY

The aromatic herb Artemisia is the sole source of artemisinin, which is the essential ingredient of WHO-recommended treatments for malaria. Diversification is the key to improving quality sources of artemisinin supplies, hence stabilizing the market and making ACTs more affordable, says the Artemisinin Enterprise.

by Elspeth Bartlet

Artemisinin-based combination therapies (ACTs) are recommended by the World Health Organization as the most effective treatments for malaria and have been adopted as policy by most countries in Africa and Asia. However, actual deployment of these medicines to malaria sufferers has been slow. A major barrier to their uptake is cost: ACTs are many times more expensive than the drugs they are replacing (such as chloroquine). Both government programmes and parents of children with malaria struggle to pay for ACT drugs, compounded by the fact that children under five often suffer from malaria multiple times each year.

A significant driver of these high prices is the cost of artemisinin production: artemisinin derivatives can account for 35-70% of manufacturing costs (depending on formulation and co-ingredient). Artemisinin is derived from the medicinal plant Artemisia annua, but the plant only produces tiny amounts, which makes artemisinin expensive to produce. The situation is made worse by uneven supplies which have caused prices to fluctuate from US$250-1700/kg in recent years. Variable quality is an additional problem.

Three organizations with support from the Bill & Melinda Gates Foundation have formed the Artemisinin Enterprise, an advocacy coalition of R&D projects developing new and diverse methods for producing high quality artemisinin. Together, these strategies will stabilize the supply and diversify the sources of high quality artemisinin, lower the cost of artemisinin production and develop new antimalarial combinations; making ACTs accessible to far more of the people who need them.

The Artemisinin Enterprise comprises:

• a collaboration led by Institute for One World Health (iOWH) to develop semisynthetic artemisinin through fermentation;
• the Centre for Novel Agricultural Products (CNAP) of the University of York, which is applying fast-track breeding technologies to develop new, high-yielding varieties of Artemisia annua plant;
• The Medicines for Malaria Venture (MMV), working on novel therapies for treatment of malaria.
Semisynthetic artemisinin through fermentation

A partnership of the Institute for One-World Health, University of California, Berkeley, Amyris, and sanofi-aventis called the Artemisinin Project, is using synthetic biology and classic chemistry techniques to develop semisynthetic artemisinin. Over the course of the grant, the project aims to create, optimize, scale-up, and indus-trialize microbial production systems to make bulk artemisinin available for incorporation into ACTs, at a low price with consistent high quality. A second source of artemisinin, in addition to plant-derived material, is needed to ensure global supply needs can be fulfilled due to current market volatility. If technical benchmarks are achieved, the project would progress to the commercial manufacturing phase with the goal to facilitate integration of semisynthetic artemisinin into the supply chain and ACTs by 2010.

Fast-track breeding of Artemisia

The Centre for Novel Agricultural Products at the University of York is using the latest genetic technologies to fast-track the plant breeding of Artemisia and increase plant output. “This plant is little changed from its weedy origins and there is a lot of scope for improvement” explains project leader Dianna Bowles. “If we can double the plant’s yield of artemisinin, we will half the costs of cultivation and extraction”. Thousands of plants are being screened for their artemisinin content and other useful features. This screening of traits is backed up by DNA screening that can pick out plants with the genetic potential to improve yield. Plants selected by this process will be used to breed new high-yielding, non-GM plant varieties. The project has adopted a non-GM strategy in order to minimise the regulatory burden the novel varieties will face.

A new class of synthetic peroxides

The artemisinin molecule contains a peroxide chemical bond, which is believed to be essential to its anti-malarial activity. The not-for-profit organization Medicines for Malaria Venture (MMV) is collaborat-ing with a number of research partners including the University of Nebraska, Monash University, and the Swiss Tropical Institute, on the development of a new class of antimalarial compounds, dubbed the “Next Generation OZ” compounds, that have a similar peroxide moiety.

“The OZ team is now testing these next generation compounds to find drug candidates that could potentially have different properties to artemisinin,” said Ian Bathurst, Director Drug Discovery and Technology, MMV. “The goal is to find an alternative to current artemisinin-derived drugs that will be cheaper and more effective. We already have a single-dose cure in an animal model and are now planning to run a clinical trial in humans.”
Health products

Highest immune response yet in TB vaccine trial

Jerry Sadoff, President of Aeras, tells us the good news

>> INTERVIEW WITH JERRY SADOFF

SUMMARY • A vaccine in Phase 1 trials in South Africa has shown the highest CD8 responses – which are important for TB protection – of any TB vaccine candidate so far. The trial was small, but preliminary data from animal studies suggest the vaccine does protect against childhood TB.

With its growing drug resistance, and clever manipulation of the immune system, the slow-growing, air ‘breathing’ tuberculosis mycobacterium is a challenge to medical science, and particularly to researchers working to produce a vaccine. So recent news that one of the several vaccine candidates – the AERAS-402/Crucell Ad35 vaccine is producing a strong, positive immune response is very welcome. RealHealthNews interviewed the President of Aeras, Jerald Sadoff, about the result.

> RHN: Can you tell us exactly what this vaccine is?

JERRY SADOFF: It’s a non-replicating virus, an adenovirus Ad35 viral vector that makes TB antigens when it gets inside cells. We’ve tested it in the United States, in a Phase 1 trial, in people that had not been primed with BCG… [BCG, a weakened cattle TB strain, has been very widely used, since its introduction in 1921, as a childhood vaccine to provide limited protection against human TB]

…and then we went into South Africa and we tested it, in the Phase 1 trial, in people that had had BCG at or near birth. And we started at low doses and then we went up to higher doses.

At the highest dose, we gave one group one vaccination and in the second group two. In both those groups, those that responded – and it’s about a 50-70% response – we found CD4 responses which were quite good, and we got some of the highest CD8 responses that we’ve seen for a TB vaccine, or for most vaccines that have been tested in humans to give CD8 responses… [CD8 cells, part of the immune system that helps kill TB bacilli, form an important arm of the body’s protection against TB]

…We saw this primarily in this group in South Africa where they had been given BCG before. We didn’t see quite such high responses in our studies in the United States.

Now, I have to emphasise these are very preliminary results.

> RHN: Well, sure. It’s a Phase 1 safety and immunogenicity trial.

JS: And the numbers are small. At the higher doses of three times ten to the tenth viral particles it was really only 20 volunteers, of which a couple from each group are placebos. The trial is still blinded so it’s really in about 16 volunteers that we saw the responses at the high dose.

> RHN: Right, so it is pretty early.
**JS:** Pretty early, but we were excited about it, because at least in the field of TB, most vaccines that have been tested so far in humans do not induce CD8 responses and it’s been recently shown that CD8 responses, at least in primates, are quite important in protection. So this gives more of a balanced response than we’ve seen before in other vaccines, and that’s why we thought it was important.

Now like I said, it’s preliminary and we have to repeat it with larger numbers of subjects. And, in fact, the study is going on right now in St Louis in the United States, where we’re actually giving people BCG and then waiting different lengths of time and then boosting them. So we’ll be able to see it in a much clearer way and in greater numbers.

**RHN:** Do you have any understanding of why it has this effect in the BCG-vaccinated people?

**JS:** Well, it turns out, we designed the Ad35 vector, that we made with [the Dutch vaccine company] Crucell, to contain antigens [molecules that trigger the immune system] that are also in BCG. So BCG makes some of the same antigens that are in our vaccines. So it’s part of what we call a ‘prime-boost regimen’ where you prime with BCG and boost with something else.

Our ultimate goal is to make a recombinant of BCG that actually makes more of the same antigens that are going to be in the boost, and we’ve got those made and they should be going into humans this year as well. In our animal studies in non-human primates, we show even better responses when we prime with the recombinant BCG and boost with the BCG. But what we have now in humans is just BCG followed by the adenovirus vaccine.

**RHN:** Yes, but the BCG is a childhood BCG in this case – so the ‘prime’ was a long time ago in adult patients.

**JS:** That’s what amazing – how long that prime effect lasts, it’s simply remarkable. All along the way people could be exposed during their lifetime to organisms that may have something like these antigens in the environment, so we can’t prove that... But it is pretty remarkable, like you say that with BCG given at birth, you do see this very long priming up.

BCG you know, and our recombinant BCGs when we vaccinate, probably stay around in the body for a month or so. It is very unusual for vaccine to persist so long. Maybe that’s why it is such a good priming agent for later coming back with boosting.

**RHN:** How good is BCG alone at protecting?

**JS:** BCG itself has been tested in lots of Phase 3 trials in the last 60-70 years. Early on and up to the 1950s, it looked like it was working, at least in the Northern countries. But in the most recent study, which is in the 1970s in India, a very large study which had over 200,000 volunteers didn’t show any efficacy at all.

However, the reason we use BCG even though it doesn’t work well, is that it probably saves between 40-70,000 lives [each year] because it does protect against disseminated disease [rampant TB, normally a disease of the lungs, that has spread to other organs of the body].

So we know BCG works to prevent, to a fairly large extent – 70 to 80% – against TB in places like the brain and in the bone. And so that’s why WHO continues to recommend its use worldwide to save at least those children’s lives. That’s why we can’t abandon it, we have to either improve on it or substitute for it with something that’s as good.

**RHN:** So if it was only effective against disseminated TB, why use the BCG antigens again?

**JS:** Why do we use it at all?

**RHN:** Yes.

**JS:** BCG makes a lot of the same antigens that TB makes... and when you look at people that have got TB and have controlled it, they have made good responses against these particular antigens. That’s how they were chosen. But I don’t think that BCG ‘presents’ the antigens to the body in a way that necessarily makes it protective, that’s the problem.

---

**RHN:** Is it not possible that you’re getting this response to your vaccine simply because you are so to speak, detecting the BCG vaccination that’s already taken place? It still may not have any effect on the TB infection.

**JS:** Yes, and that’s an excellent question. Along those lines there are two things. We’re looking at BCG, or recombinant BCG boosted with this vaccine in non-human primates, where we can actually challenge them [with TB itself, to see if the vaccine protects]. And our preliminary data from in the Netherlands shows that the recombinant BCG boosted with this vaccine does give protection against childhood TB. But that’s also preliminary data and has to be repeated, and we’re doing much larger studies now.

And the second thing we’re going to do to prove this, is we’re going to have to go into infants, which we could go into in South Africa, where we’re doing our trials, because they have a very high rate of [natural] infection there, and we can actually test a relatively small number – somewhere between 7-800 – and compare it to BCG and see if it gives better protection. So we’ll actually look in infants.

I agree with you, your question is the question we have in the field – will these better responses actually give better protection. The only way to answer that question is by actually doing protection studies in non-human primates and in small-scale test-of-concept studies. And we’re doing them.

---

This interview continues on our website [http://www.realhealthnews.net](http://www.realhealthnews.net)

The Aeras Global TB Vaccine Foundation [http://www.aeras.org/about/index.html](http://www.aeras.org/about/index.html)

Crucell [http://www.crucell.com/AboutUs](http://www.crucell.com/AboutUs)

Press release on the AERAS-402/ Crucell Ad35 vaccine [http://tinyurl.com/55lydj](http://tinyurl.com/55lydj)
Diseases

80% of diabetes in the South

Figures to double by 2025 – can research help?

EIGHTY PER CENT of people with diabetes in the world live in developing countries, where the number of people with diabetes is predicted to increase by 150% in the next 25 years, according to the World Health Organization (WHO). Even in the next ten years, diabetes deaths will increase 50% without urgent action. And the International Diabetes Federation (IDF) estimates that 3.8 million people died as a result of diabetes in 2007. This is more than deaths from HIV/AIDS and nearly four times the deaths from malaria.

So in this context, what research should be underway, to help developing countries face the scourge of diabetes? Surely the best way to find out is to ask the countries themselves. So the European Action for Global Life Sciences – EAGLES – commissioned the Editor of RealHealthNews, Robert Walgate, to talk to leading diabetes researchers and practitioners in countries in Asia and Africa and ask exactly that question, reporting his conclusions back to the Commission of the European Union [EU] in Brussels and the European Parliament. Here is a brief summary of what we heard. Key recommendations are marked by bullets.

JEAN CLAUDE MBANYA, President-Elect of the International Diabetes Federation, spoke to us from the low-middle-income country Cameroon – one of the few well-studied developing countries thanks to a EU research programme comparing diabetes in Africans in Cameroon, the Caribbean and the UK in 1994.

“In 1998, the prevalence of diabetes was about 2%,” said Mbanya. “In 2003 it was already 5%, and 2007 it is going to be about 6.5%.” It's a dramatic rate of increase, and it extends to the rural areas, “where you get so many people now with impaired glucose tolerance, and impaired fasting glycaemia” – precursors of diabetes.

“If you look at obesity, which is one of the major risk factors for diabetes in Cameroon – it's about 16% in the rural areas. And nearly 30% in the urban areas” said Mbanya.

“I don't think it's mostly nutrition, I think it's mostly a more sedentary lifestyle – a change of physical activity. It's the Chinese phenomenon of having motorbikes everywhere. Where they used to walk to places, now they have a bike.”

- So what research would be useful?

“I think first of all you need to produce data to convince the government. I think it also helps very much when you have a local champion – because he or she at least can work towards the achievement of certain goals. And also you need a team, like mine, to carry out the surveys and assist the government.”

- Economic studies are also crucial:

“Some data, no matter how it is collected, is better than no data!” said Mbanya. “You can do hospital analysis of admissions, bed occupancy and deaths, for chronic diseases and the rest. Over a period of time you would see that the greatest burden is maybe diabetic foot – the foot ulcer; they stay in hospital for three months, or the foot is amputated. If you look at the economic burden imposed by diabetic foot on the hospital, you’ll see that it chops off a whole chunk of the budget! It's more than malaria, tuberculosis, AIDS and the rest!” It can become a priority therefore to deal with that.

MAHEN WIJESURIYA, Chair of the IDF South East Asian Region, speaking from Rajagiriya, Sri Lanka, told us that two million people had diabetes in his country, out of a population of 20 million – a rate of 10%. In the urban population 16% – one person in six – has diabetes, and in the rural areas it is about 8%. “And the figures might double by the year 2025” said Wijesuriya.

There is a similar pattern in India and Bangladesh, he says – “All of us are running around 16-20% in the urban population – we are the double-digit boys.” And in Sri Lanka “we have care in quality but not in quantity” said Wijesuriya.

- And research?

Wijesuriya emphasised the value of “translation research” – where investigation is made of how to translate academic research into practical action. So with IDF support Sri Lanka is investigating the development of proven life-style risk factors – such as poor nutrition and little exercise – in children, “where we have committed ourselves to intervene in life-style changes, over three years”.

“We want to use these [risk] factors to see if we can bring down the incidence and prevalence of diabetes in our community” said Wijesuriya. “We hope to make this a landmark study where others could follow.”

These studies to create positive interventions could be made on the basis of the “four agreed major causes of diabetes: genetic factors, intrauterine nutrition [principally poor nutrition of the pregnant mother], life-style after birth – and mental stress”.

SUMMARY

Developing countries tell EAGLES, the European Action on Global Life Sciences, and RealHealthNews, the research that’s really needed.
What about research to bring down the cost of treatments (primarily drugs for late onset type 2 diabetes, and insulin injections for childhood type 1), we asked?

"Now you've hit upon the sensitive point. When they got human [cloned] insulin, we all thought it was a bonanza and we were going to get enough cheap insulin. But the price never came down, and it is now going up again, away from the poor man's pocket."

"That is where something can be done from the richer part of the world, with equitable distribution of production, and cost-factor analysis… We don't want the insulin producing companies to go broke. But we want good insulin, cheap."

LI LIU, a paediatric diabetes physician at Guangzhou Children's Hospital, China – told us: “95% of the diabetes at this hospital is of course [childhood] type 1. It's easy to diagnose here, but it's often misdiagnosed in the countryside, if they aren't aware of it, for things like nausea and abdominal pain.” This is a consequence of the ketoacidosis that follows a diabetic child's lack of natural insulin.

In consequence, a lot of her patients arrive late – and unconscious, in a coma, says Li. The first need of all her patients is medical insulin, she says. But they must pay – and a lot of them have to have insurance cover. "It's very expensive compared to their income," she said. "So some of them give up the treatment." And the child dies.

It costs US$ 700 for the first visit, and then US$ 40-70 for a period of treatment – usually about a month – until they become stable, using insulin injections and blood sugar tests, said Li. "Then they go home, and then they have to continue the treatment, injecting at least twice a day for life, and testing their blood sugar" said Li, at a cost of around US$ 40-70 per month.

"We have many neonatal cases, and sometimes the parents give up" she said. "They think the children will face education problems, marriage problems, and employment problems... You know in China parents prefer sons. I met a nine-year old patient, a girl, and her parents were very poor and they said she would cost us a lot of money... we will raise another child, and not continue treatment." Also, universities and employers are obliged to pay their students' or employee's medical costs. So although it's illegal they find reasons to exclude diabetic patients. "Some diabetics, when they reach puberty, want to commit suicide," said Li.

KAUSHIK RAMAIYA, a physician and researcher in Tanzania, stressed the need for:

• Research in population-based epidemiology of diabetes. "We have nothing significant outside South Africa, Tanzania and Cameroon," he told us. "We need help to get these basic epidemiological studies done, to identify the state of the problem... Then we need to get the risk factor profiles."

“We also need to strengthen the healthcare system itself – infrastructure, tools to make the diagnosis, like a basic ophthalmoscope for eye problems. You need tools to identify and diagnose the complications." But totally new tools aren’t needed – just the availability of the one we’ve already got. “And then you need the training how to use them.”

• "Health systems research could identify the gaps within the resources, in the training, in the equipment, and find ways to fill up those gaps" he said. "We also need to improve the supply and logistics systems, especially for life-saving drugs like insulin. We need insulin at an affordable cost, but then we need to get it from urban right out to rural areas.”

SHAUKAT SADIKOT, President, Diabetes India, told us: “Everyone will tell you the problem is prevention; it’s important, but quite frankly the problem in India right now is that a lot of people who have diabetes don’t even know they’ve got it. So they present with complications.”

"In the rural areas, four out of five people with diabetes didn’t know it. Even in the major cities, it was one out of two. So one of the main things is to inform people.” Also “98% of patients are treated only by family physicians, and that doesn’t mean physicians who studied allopathic [modern] medicine. It might be someone who’s done ayurvedic or homeopathic medicine and so on…. So the basic problem is creating awareness – amongst the doctors and amongst the public.”

"First you need data to convince government” says Jean Claude Mbanya, President Elect, International Diabetes Federation.
> Health Systems

US$25 million for health systems research

The new Instituto Carso de Salud will invest US$ 25 million annually in bright ideas for health systems in Latin America

>> INTERVIEW WITH JULIO FRENK

SUMMARY • Mexican businessman Carlos Slim has given half a billion dollars to set up an institute to seek new approaches to primary health care in Latin America. The mobile phone – one of the sources of the benefactor’s wealth – may play a leading but not exclusive role. RealHealthNews interviewed its Executive President, Julio Frenk.

>JF: For me philanthropy is another form of public service, but it has very many differences from government. It has been called the ‘third sector’, in a sense equidistant between government and private commercial enterprises. Its main strength is flexibility. You don’t have to face voters, or the same degree of bureaucratic procedures, and much more freedom that private enterprise to take risks, because you don’t have to make a profit or satisfy shareholders expecting their return. So philanthropy is really playing a huge role today in global health – not only because of the amounts of money but because of it is being spent with great flexibility, taking big risks.

>RHN: What is your actual funding – how much have you got to spend?

>JF: Carlos Slim made a gift to the Institute as an endowment of US$ 500 million. Usually the payout, in almost every foundation in the world, is about 5%, which should allow you to conserve the real value of the endowment. That means we have a budget for the support of projects of the order of US$ 25 million a year.

>RHN: What kind of people are they?

>JF: The Director is a very accomplished public health professional, Roberto Tapia, who served as Under-Secretary for all the prevention programmes in Mexico, when I was Secretary of Health in Mexico. It’s a mix of public health professionals with a few experts in grant making and philanthropy – of which there are very few in Mexico, because truly this is a very new field.

>RHN: ‘Experts in philanthropy’ – frankly I don’t know what that means!

>JF: It’s people who know the process of how to analyse grant applications, structure committees to make decisions, how to allocate the funds – it’s quite technical. And apart from the Board, chaired by Marco Antonio Slim, our benefactor Carlos Slim’s second son, it relies on two committees, an international advisory committee and a scientific advisory committee. The international committee has broad representation from the Americas and Spain, and meets annually; the scientific advisory committee is made up of people living in Mexico City as they meet at much more regular intervals and go over many of the proposals for their scientific merit.

>RHN: Is that significant, in Latin American terms?

>JF: It is very significant – it immediately places the Institute as one of the largest foundations in Latin America, in any field. But I have to say that Latin America, of all the regions of the world, is the one where there is the least amount of philanthropic giving – in relation to income per capita. Even in Africa, in proportion to income per capita there’s more philanthropic giving than here.

>RHN: That’s staggering! But I want to ask you something completely different now – how you hope to use the Institute to implement your vision, which you expressed at the Health Research Summit in Mexico in 2004, and many times since – of connecting evidence with policy-making and action. How is that going to work, in practice, in this region?

>JF: Yes – it is very important that while philanthropic organizations exploit their advantage of being flexible, they recognize that they need to work with government and private commercial enterprises. Because all the money that’s going into philanthropy, for example at the Gates Foundation where I work one week every month, is still very small compared to the scale of problems – or to the money that governments have to hand, or private commercial enterprises.

So to me the value added of philanthropy is the ability to take intelligent risks. It can demonstrate innovations that then should be transferred either to the government or to private enterprise.
They’ll need to be scaled up.

JF: Exactly.

RHN: Give me some examples of the sort of project that could be undertaken – or will be undertaken – by Carso Salud.

JF: The institute has six priorities – they’re very specific – but let me give you a couple of examples. One of the most interesting projects we have is a new form of organizing the delivery of primary health care, through what we are calling ‘social franchises’.

So these are units that are owned by the doctors and the nurses, in a sort of cooperative model of medical work, that are located in rural areas or poor suburban areas. The institute provides support in the form of a credit line – financial support.

Obviously there are thousands of experiences of small units, non-governmental for example, working in such areas. But the two main problems up to now have been that there is huge variation in quality; and because they are small they don’t have economies of scale – so they purchase drugs at very high unit prices.

Well in the business world, those two problems were solved with franchising. Franchises standardise quality, and then they aggregate the various units to create economies of scale.

Very interesting.

JF: So we’ve taken that idea and we call it ‘social franchising’. It’s franchising but it’s ‘social’ because its purpose is not to make a profit, just to be financially sustainable. The idea is we use those clinics to ask if in the 21st century, primary care could work like this. Because you know that in the 20th century, a lot of primary care became primitive care.

The idea is now to mobilize for example the telecommunications revolution – that’s one of our top priorities. The largest share of our benefactor’s wealth comes from telecommunications – but we think it can be used to solve the health problems of the very poor. So these social enterprises would provide a platform for intensive use of mobile phones, with telemedicine to bridge the distance gap.

RHN: I want to take a very specific case of a health problem, connected with poverty, in Latin America – as we have a story on it in this issue of RealHealthNews [p.28]. It’s the problem of HIV/AIDS among the displaced in Colombia. Now there you have country that is more or less in civil war; you have a terrible challenge both with distributing health care and with these displaced persons.

What kind of thing could be done by a group like Carso Salud, to help?

JF: Well our main role is to run demonstration projects, to demonstrate innovations in health systems. Obviously the problem you are addressing is mostly a problem of government and international humanitarian organizations – and also of the United Nations system – which have structures to deal with these problems and with displaced persons.

But what we can bring to that kind of situation, and in general the situation of populations that are marginalised or excluded from the main stream of health systems, is to use projects like the one I was describing – show specific innovations in the way services can be brought closer to these people.

For example telemedicine bridges the distance gap. That’s very relevant for displaced persons where you may have just one community health worker. If there’s one thing we know, it’s that community health workers are a great solution to problems if they are connected. They usually provide very poor quality if they are isolated. So providing connectivity between community health workers, or basic grass-roots clinics, to higher levels of complexity and knowledge in the health system is one of the applications we are working on.

RHN: So that provides the community health worker with what – a sound base of information and advice, potentially the possibility to order needed supplies, and perhaps a stronger sense of community with professionals?

“A mobile phone allows the worker to seek help if he or she is facing a problem with a patient that they can’t solve.”

JULIO FENK

JF: Yes, it allows the worker to seek help if he or she is facing a problem with a patient that they can’t solve. They could get information or even send pictures to a call centre with specialists to get advice on how to stabilize a patient or even carry out emergency procedures to deal with an acute problem. That’s the sort of innovation we’re pursuing.

We’re what’s called a ‘second floor’ institution, not a direct provider of services, or a humanitarian organization, but we will invest in the design of solutions that can then be brought to scale either by government or others.

RHN: So if there were groups with some clever ideas in Colombia about how to deal with the health of their displaced, they could apply to you to test their ideas out?

JF: Absolutely. That’s exactly our mission.

READ ON

This interview continues on our website:
http://www.realhealthnews.net

The Carso Health Institute
http://www.salud.carso.org/tm_infor_ing.html
Preventing HIV/AIDS in young displaced Colombians

Self-esteem and a life project help disturbed youngsters

**Summary**

A focused, local and innovative programme for preventing HIV/AIDS in young people is proving helpful to teenagers displaced by conflict in Colombia. Funding is coming to an end, but a demonstration project could prove its worth for future donors – and other countries.

**by Lisbeth Fog**

Over four years more than 200 000 Colombian young people have been trained in reproductive health issues, stressing the prevention of HIV/AIDS, in a US$ 8.6 million project of the Global Fund to Fight AIDS, Tuberculosis and Malaria that will come to an end and face its final evaluation in July. Already it has an “A” rating from the Fund.

In an adjacent article in *RealHealthNews* [p.26], the Executive Director of the new Instituto Carso de Salud, Julio Frenk, has made an offer to support a demonstration project for any innovative ideas that may have arisen during the project – if they are sufficiently clever, and might be used elsewhere. And no doubt these ideas are here – it will just be up to the participants to identify them and apply.

Indeed, this has been no simple health education project, because it has focused on youngsters displaced by the constant harassment of Colombia’s internal conflicts, in a country where this problem is getting worse each day. For this project obstacles are its daily bread.

Almost three million people in Colombia (7% of a national population of 42 million) have left their lands in recent years, due to the conflict between the government and rebel groups. Most try to reach the cities – where they hope they will find life better. But as in much rampant urbanisation throughout the world, dreams are not always borne out by reality.

Instead, most of the displaced face rootlessness and social exclusion. According to the project documents [see Global Fund link below] they often end up in “… marginal urban areas of extreme poverty, dropping out of school, social uprooting, family pressures to contribute economic resources, despair and uncertainty on a daily basis, and frequent exposure to sexual abuse”.

Lacking alternatives, they often fall into “… irresponsible, fatalistic and reckless sexual-...
one woman for every two men. Some 18% of them are 15-24 years old, and 65% are 25-44 years old, which means, according to the Ministry, that this latter group – which is the most affected – probably got the infection before they were 20 years old.

As a consequence, authorities think it is imperative to work with people from childhood and adolescence, in the hope of preventing adults becoming infected with HIV/AIDS.

Since 2003 public health policies in Colombia have followed the UN General Assembly Declaration of Commitment on HIV/AIDS, which the country signed in 2001.

Minister of Labour and Health Diego Palacio told RealHealthNews: “This commitment has been reinforced through the Millennium Development Goals – which means that the country in 2015 will have a prevalence of HIV infection below 1.2%, improve the access of antiretroviral drugs, reduce mortality due to AIDS, diminish the number of cases of perinatal transmission and increment the use of protection measures, as the condom, specially in young people”.

The project is the only one that takes the displaced population as its main target, and, most important, stresses in preventing adults becoming infected with HIV/AIDS.

Even though the project involves international cooperation and the support of national government, it works on the level of municipalities – involving local political leaders, as well as the municipal education and health sectors, to ensure the access and the quality of the services for the young and their sexual education.

With all parties involved, the project has settled alliances, trained health workers and teachers, facilitated access to health services for young people, developing ‘friendly’ services, offering free HIV tests and consequently the treatment in positive cases, with strictly confidentiality. It has also organized workshops and meetings so the issues it addresses become part of the local political agenda.

This training program includes workshops of sexual and reproductive rights, capacity building in designing and developing socially and economically productive projects, called young enterprises.

But mainly the project aims at multiplication: training young people from different localities so that they become the multipliers of the information and understanding to other young people in their turn.

Almost 145 groups representing the 48 municipalities of Colombia have been organized. Called ‘young enterprises’, their projects are starting to generate income. The include promising industries for the production of snails, stevia (a plant used as a sugar substitute), and ecological paper; and cultural and artistic groups to enhance abilities, such as rock, rap and metal groups, as well as dancing troupes.

Considered as one of the most important results of the project, these new occupations for the youngsters has given them a possibility to create a sense of the future – a life project – and as a result their self-esteem has strengthened. And as this is part of the program, they know now the importance of taking care and respecting their bodies and themselves as people with rights.

However the project is challenging. Many of the 48 Colombian townships are in isolated regions, lacking good means of transportation, equitable health services, modern technology – or even security.

The political and social situation has also inevitably threatened the progress of the activities in some regions. But the enthusiasm of the young people is thrilling. “We are still in the first stage of our enterprise”, said one of them, showing the snails he is cultivating in Bogotá. “But our idea is to export them in the future!” Dreams that could come true, no matter the difficulties these young adults have experienced in the past. ■
Goa — health at the front line

Reporting from the old Portuguese maritime state of Goa, in Western India, our correspondent Rupa Chinai asks what health care looks like from the patients’ perspective. She identifies major problems that need to be solved, both by researchers and by policy-makers, and offers a way forward. Her report is an indicator for all of India — and for many other countries with challenged primary health care systems.

Ideas for good health research and policy interventions, it is said, are born out of good observation. India’s cultural and geographical diversity does not lend itself to tailor made remedies. The studies from Goa do however conform to trends noted elsewhere in the country — the crying need for comprehensive services based on a strong primary and referral system. This was one of the key perceptions on India’s health policy articulated at the time of Indian independence by the Government appointed Bhore Committee. People who had roots deep in the Indian soil further developed this vision. Their work has demonstrated how this approach can make a difference in the lives of the poor within communities.

Unfortunately, the country’s policy makers, influenced by Western donors, undermined this excellent blueprint for Indian health. Right from the time of India’s Independence in 1947, the country has seen an emphasis on ‘vertical’ or stand-alone programmes that have ignored the community’s need for comprehensive health services. This has placed enormous pressure on existing staff who cannot cope with the target driven programmes and their misplaced emphases.

Research in Indian health requires partnership with local communities to understand and articulate their concerns. It needs field-based epidemiology rather than extrapolations that have no basis in ground reality. It calls for an understanding of the wider socio-economic linkages to understand what factors shape people’s health and health seeking behaviour.

Without such insightful research India’s health agenda will continue to lurch from one meaningless priority to the next. Its public primary health system will remain a mere shell while its referral services will continue to be overloaded and increasingly at the receiving end of public rage when patients continue to die from negligence, wrong diagnoses and lack of drugs. The current push towards privatization and reduced subsidy to public health care will meanwhile leave the poor with little option but to quietly lie down and die.

The performance of the health system in Goa, despite the State’s remarkable achievements of over 82% literacy rate and second highest per capita income in India, is symptomatic of all these challenges.

While the Government of Goa claims a wide network of primary health centres and referral institutions, real health serv-
ices do not match up to the investments made in buildings and equipment. Policy makers may be trying, but they are also failing to solve the real problem on the ground – caring for the health of the poorest.

A huge work burden and ill-motivated staff plague the primary health system in Goa. Access to services remains a huge issue for Goans in the rural areas. Many primary health centres here suffer from vacancies, poorly trained and motivated health staff and lack of essential drugs, while higher-level referral institutions are overloaded with patients, super-specialists and expensive machines.

Compounding this is constant political interference in the name of improvement. At the Sanquelim primary health centre in the Bicholim taluka (local administrative area) for instance, all the administrative staff were recently removed and transferred to the primary health centre of a different taluka, an official revealed.

“This trend started with the earlier government when everyone from the doctor to the peon [clerk] was transferred. Now this continues with a new government in power. The local Member of the Legislative Assembly is helpless to prevent it because he belongs to the party that initiated the first spate of transfers. They are making a mess. Everyone is new here and they do not know anything about this area”, a health official said.

Meanwhile there is a growing trend of private medicine catering to the wealthy – and the poor who have nowhere else to go. In order to pay for urgent medical costs they are forced to cut back on other essential requirements of nutrition, education and savings.

In the interior districts of Goa, the 41,000 residents of Canacona have recourse to no more than 60 beds at the health centre, journalist Rahul Goswami has reported. Patients are forced to share a bed with others, irrespective of whether they might pass on an infection. The centre’s X-ray machine has not worked for over a year; the kidney dialysis machine cannot work for the poor quality of electricity and the absence of a generator, says Goswami.

Goan women in the rural areas face a particularly difficult time accessing health services. According to India’s National Family Health Survey NFHS-2, for almost 30% of rural women a primary health centre is over 10 km away.

The survey further reveals that two in every five married women in Goa report some type of reproductive health problem; of these, close to 60% have not sought any advice or treatment. The results of the NFHS-2 show the need to expand reproductive health services in Goa. There is also need to launch information programmes that encourage women to discuss their problems with a health-care provider, experts said.

Rural Goan health centres, however, lack health providers to provide these services. A visit to the Curchorem Community Health Centre in Quepem taluka reveals key staff vacancies.
doctors – one health officer (a senior administrative post) and two medical officers – when officially there should be five.

In an emergency, such as the one they had had the day before my visit – when several severely injured bus accident cases were brought in – the services of a private doctor had to be sought. This centre sees many cases of dog bites, but no anti-rabies injections are available. There have been several cases of death from rabies, but these have not served to sharpen the response of the centralized drug supply depot.

According to Raj Vaidya, a pharmacist at Hindu Pharmacy in Goa’s capital, Panjim, and a secretary of the Voluntary Health Association of India, Goan division – VHAI-Goa – the State still does not have a rational drug policy that ensures that essential drugs relevant to local needs are made available to the network of health centres across the state. Doctors have a tendency to prescribe expensive drugs and dietary supplements, influenced by the companies that aggressively promote them, he said. “We see a lot of prescriptions from the Government Medical College for iron and calcium tablets which are costly and should not be prescribed to the poor. A slum woman would be better off spending that money on vegetables and fruits instead”, he said.

Tuberculosis

TB is another monster in Goa’s health system. The Revised National TB Control Programme (RNTCP) estimated that there are 160 cases of TB per one 100,000 population in Goa. The programme however has failed to meet its target of detecting 70% of new cases. It has also failed to follow-up defaulters who start treatment but do not complete it. The programme in Goa has failed to meet its targets because of its dependence on a weak primary health care system, a pattern also found in the rest of India.

According to an RNTCP senior treatment supervisor, Goa – along with Pondicherry (a former French colony, on the South-West coast of India) – has the country’s highest rate of defaulters (patients who do not complete treatment). This is largely because of its migrant populations who have no fixed address, the supervisor said.

Incomplete treatment results in one TB patient spreading the infection to at least 15 other patients, he said. Although primary health centre staff must visit patients in their home and motivate them to continue coming to a DOTS (Directly Observed Treatment, Short Course) centre for their regular TB drug dosage, they have failed actively to pursue cases, said the supervisor.

Private practitioners in rural Goa said the RNTCP has not sought their help in supervising the drug therapy of TB patients being treated under DOTS.

The RNTCP started in September 2004 in Goa and provides free treatment to patients through DOTS provided at their

Kidney disease anaemia the main complaints

In rural Goa people have to contend with both non-communicable diseases along with the older communicable illnesses. When asked for what they considered to be their main health problem, residents of Barceim village in Quepem taluka [administrative area] said it is kidney failure. The village has a large number of women in the age group of 30-50 suffering from this problem. They also said that women suffered from an excessive loss of menstrual blood. Other illnesses related to jaundice and fever.

The complaint of kidney problems appears to be a serious issue in Quepem and neighbouring Canacona taluka. While some doctors said it is likely to be linked with the low levels of ground water and its metal contamination, the issue does not seem to have impinged on the state authorities so far. Kidney disease has a crippling economic impact on the patient and their families.

The excessive loss of menstrual blood amongst women in Barceim may relate to the high levels of anaemia. The villagers however suspected the excessive blood loss is related to women’s kidney problems.

Dattaram Desai, a private GP in Savorverem, Ponda taluka, said common ailments treated in his GP practice relate to throat and chest respiratory infections, worms in children, tuberculosis and anaemia in women. “Food habits of people in rural Goa are not good”, he said. “They do not know what food is nutritionally rich or that their diet lacks iron and vitamins. Women suffer from anaemia because she is the last to eat - after feeding children and the men folk. In addition to her work for the family she augments the family income through her work in the fields. She is the most suffering person and her anaemia gives rise to a number of infections”, he said.

That the problem of anaemia is widespread amongst Goan women came up repeatedly during the course of enquiries. The average haemoglobin level of the Goan woman is 8 gm/dl [compared to a ‘normal’ haemoglobin value for Indian women of 12-16 gm/dl], says Raj Vaidya, a pharmacist at Hindu Pharmacy in Goa’s capital, Panjim, and a secretary of the Goa branch of India’s Voluntary Health Association.

Kidney disease anaemia the main complaints
nearest government health centre. Each patient has a box containing his or her entire supply of drugs. The medicines are kept at the nearest public health centre, where the health worker ensures drug compliance and should follow up if the patient fails to turn up regularly.

The patients are first detected during their visit to a public health centre, where the doctor, suspecting TB, refers the patient to one of the 18 designated microscopy centres specially set up by the RNTCP to ensure accurate TB diagnosis. A TB Unit, covering a population of 500,000, ensures supervision of the RNTCP in their area.

Enquiries into the functioning of Goa’s TB programme revealed that many patients are simply unaware of the RNTCP and the fact that they can access free treatment. Pushpa, a patient with extra-pulmonary TB, said that a doctor at Goa Medical College had detected her disease – but nobody had told her about RNTCP or the DOTS programme. She has been taking treatment from a private practitioner.

Such lack of awareness is particularly widespread in the interior areas of rural Goa. The incidence of undetected TB is particularly high in areas like Madkai, Ponda district, where poor communities like the Gauddes are badly affected. The pressure of daily survival prevents them from seeking treatment until the disease has advanced to its final stage.

In cases where patients do seek treatment, they are defeated by the long distances they have to travel, often over two kilometres and sometimes even 35 – a long way for a sick or elderly person to walk to reach a DOTS centre. The paucity of public transportation in Goa is a huge problem [see box page 35].

Meanwhile the low detection rate of new TB cases is because of the programme’s dependence on the medical officers in the health centre outpatients department – who must identify and refer suspected cases. Any patient having a cough for more than two or three weeks must be referred to the TB programme for sputum tests, but primary health centre doctors fail to make such referrals, the RNTCP official said.

**Cancer and cardiovascular disease**

When I arrived at a large meeting hall in a hotel in Panjim, it was packed to capacity, filled with young women coming to attend a meeting on breast cancer. Surprised by the huge turnout I assumed these were women interested in knowing how to prevent cancer. As the meeting progressed and members of the audience got up to address questions to the panel of cancer specialists, I realized with a shock that practically all of these women were in fact patients – who were either undergoing treatment or in the process of remission from the disease.

The last decade has seen a tremendous increase in the incidence of female breast cancer in Goa, said Shekhar Salkar, an oncology surgeon at the Manipal-Goa Hospital, Goa. The disease is increasingly seen in younger women around 35 years of age. In 2005 ten patients detected were in the age group of 20-39 years.

According to Salkar the profile of these patients show some common factors of risk such as high income, junk food, obesity after menopause, delayed birth of first child, not breast feeding their child for at least one year, early menarche and late menopause. In addition, 40% of the women had a ‘late’ marriage and 30% of couples did not have children because of infertility, he said.

Although there is no official data on cancer incidence in Goa, Salkar said the state records around 250 new cases of breast cancer every year. Going by these figures, based on actual cases detected, it would imply that Goa’s female population of 650,000 would see an incidence of 35 breast cancer cases per 100,000 people. The all-India figure for breast cancer cases is estimated to be 80,000 [in a population of 1.1 billion, i.e. about 8 per 100,000, a quarter of the Goa figure] Salkar pointed out.

“The rate of breast cancer cases in Goa is very high – and is comparable to the incidence in Indian metros”, Salkar said. “It is vital that the Goa government initiate a pilot study to estimate the actual number of cases detected in a field survey.
Goa sees around 600 people dying of communicable diseases – but 5000 from non-communicable diseases each year. It is high time the health system is geared to early detection and prevention of non-communicable diseases like cancer, diabetes and hypertension which are on the rise here”, he said.

Goa is in the process of a health transition with the rapid rise of chronic diseases. Goa faces a serious problem of coronary heart diseases – conforming to the pattern seen elsewhere in India – but Goan women are more prone to it, according to a recent study conducted by VHAI-Goa.

The as yet unpublished study examined 1 500 patients attending the clinic of ten general practitioners in Goa. The prevalence of coronary heart diseases was found to be very high with rates of 4-6% in men and 6-11% in women 40 years of age and above. In most cases the disease had been undetected, and patients of both sexes were at risk of a heart attack because of poor control of blood pressure, cholesterol and diabetes.

According to VHAI-Goa, there is a cardiovascular disease epidemic unfolding in Goa, and there is an urgent need to develop evidence-based interventions for primary and secondary prevention of coronary heart disease.

### Depression amidst wealth

One of the most glaring missing elements in this wealthy State’s health system – as across all India – is any serious concern for mental health, particularly among women and the vulnerable. This is the dark side to Goa’s economic success story, evident in studies highlighting a high prevalence of depression and stress-related problems in young adults and women in the reproductive age group.

This trend in Goa parallels a worldwide epidemic of depression. Globally, “depression is the most common psychiatric disorder… [it is] ranked fourth among all causes of DALYs [years lost due to disability] and… the leading nonfatal condition globally” according to the Disease Control Priorities Project.

It estimated that over a one year period, nearly one in fifty women in Goa will develop new episodes of depression, which means about 6 000 women in this age group will develop a new episode each year. Over one year, 0.8% of women will attempt suicide – some 2 500 attempts.

Doreen Dias, senior psychiatrist at the government hospital in Margao said she sees a larger number of attempted suicides amongst females in the early teen to mid-30s age group. These are usually precipitated by conflict in love affairs and relationships. Factors such as alcoholism of the father, fragmentation of families and a dysfunctional background make young people vulnerable to such behaviour. Attempted suicide by young males is not an impulsive action and is usually on account of their unemployment, and depression over a long period of time, she said.

Studies by Sangath, a Goa-based NGO which works on mental health issues within the primary health setting, reveal that one in five adults attending the primary health centre and one in four mothers attending antenatal clinics suffer from depression.

The symptoms of depression are typically expressed indirectly - through physical complaints like fatigue, aches and pains, and gynaecological problems such as abnormal vaginal discharge. Thus primary care doctors and gynaecologists are the practitioners most likely to be consulted by depressed women.

Other findings show that in mothers, the birth of a girl child is a risk factor. Sangath has demonstrated the disturbing tendency to ‘son preference’ in Goan society – and its impact on the mother’s mental health.

Depression in women is also strongly linked to the alcoholism of their husband. Alcoholism is a predominantly male affliction in Goa [see box page 31], as elsewhere in India. This alcoholism is a major risk factor for domestic violence, which in turn affects women and children. Thus depression and alcoholism affect the two sexes in different ways, but interact with one another closely. Disadvantage and mental ill health typically cluster in the same families.

Studies further indicate that babies born to depressed mothers are three times more likely to suffer from malnutrition. Boys born to depressed mothers show delayed mental development. Depression is thus a profound disability to be addressed for the benefit of the whole family.

Treatment for depression results in high out-of-pocket expenditure. Sangath investigations showed that depressed women are three times more likely than non-depressed women to have spent 50% or more of their household income on out-of-pocket health care in the previous month (independent of their other physical health problems).

While the more serious cases of mental illness and suicide attempts are referred to the Institute of Psychiatry and Human Behaviour, Goa, Dias said, “There are a large number of cases who simply do not have anyone to talk to about their prob-
lems. Many feel they do not have the support of parents. A
suicide attempt is their way of saying ‘I need help’ – they feel
they will get attention”, she said.

Nandita D’souza, paediatrician, also stressed her expe-
rience that most people merely need someone they can talk
to about their problems. Her work in child development and
family guidance seeks to create networks between teachers,
parents and communities in helping children work through
the difficulties they face.

In a pioneering move, Sangath – along with the Goa govern-
ment and the Goa Chapter of the Voluntary Health Associa-
tion, are collaborating in a pilot project, ‘Mana shanti sudar
shodh’ (Manas), launched in August 2006, to introduce trained
mental health counsellors within the primary health setting.

The Manas pilot project, soon after its launch in Goa in 2006,
showed that 10-20% of patients attending a primary health
centre are suffering from stress and depression. They are pri-
marily women in the age group of 25 and above. This pro-
gramme however is not able to reach the adolescent and
youth group who have little reason to routinely visit a primary
health centre.

Evidence of suicide by farmers in Maharashtra or weavers in
Andhra Pradesh is a further indicator of how common mental
disorders assail vulnerable groups, particularly in rural India
where no psychiatric help is available. The Manas project
attempts to examine whether treating these disorders at the
primary health level is effective and affordable and reduces
the high out of pocket costs and irrational treatment suffered
by patients at the hands of quacks.

India’s new Mental Health Policy proposes treatment of these
disorders in the primary health setting. The approach of basic
treatment along with counselling, as advocated by the Goa
experiment, is also applicable to a variety of health problems.
Trained community based counsellors situated in the primary
health centre or school, can address a variety of problems and
create awareness on prevention.

Multilingual depression?

“We see depression but we are not looking at the stressors”,
said Rajesh Dhume, a Goa-based psychiatrist. “Pro-active men-
tal health has to start with education. Goa’s education system
has not resolved the issue of the [multiple] languages used for
learning. As a result, children first think in their local language
and then translate what they are hearing or trying to convey.”

“The youth here are Konkani-speaking but their primary edu-
cation up to class four, focuses on reading and writing in Mar-
athi,” said Dattaram Desai, a private GP in Savorverem, Ponda
taluka. “The switch to English from class five onwards finds
them without a grasp of Marathi or English, while their think-
ing is in Konkani”, he said.

Continued on page 36 >
Rajesh Dhume said that “having no grasp of basic theories or concepts, such a child’s learning is based on rote. Children lacking confidence in speaking also have a reduced capacity for a problem-solving approach to real-life interpersonal problems. They cannot cope with competition from others and focus only on claiming certificates.”

According to Dhume urban children are able to get by with extra coaching but first generation learners in the rural areas are severely affected. Inability to compete has caused them stress and insecurity. How to strengthen a person’s ability to solve their problems is the key issue we face, he said.

Supporting the view that rural Goan children are unable to cope with stress, Desai said his clinic sees many young people who suffer from an acute sense of failure and stress over their inability to cope with life. This has led to several cases of suicide amongst the young, he said.

Also attributing this sense of failure to the education system Desai said, “Parents cannot provide money for coaching. The youth have no knowledge of English and their background is not conducive for academic studies. With classrooms packed beyond capacity, individuals cannot get special attention and many remain behind.”

Community health workers

One solution to some of these problems may be to train and support health workers from the community. Indian experience has repeatedly shown that the country will never have enough trained medical professionals willing to work in the rural areas; and that in practice the emphasis on vaccines, allopathic [modern] drugs and technology has failed to be the promised magic wand.

If the health system fails to deliver its goods and services to the people, how can they be expected to rely on them?

A number of groups in India working in community health have already provided invaluable contemporary experience. Deeply rooted in the community, they are demonstrating a course of action that has the country’s neediest at its heart.

One such approach is to develop a cadre of village based health workers – the ASHA (Accredited Social Health Activists) – trained in preventive and curative health. This is now a key recommendation of the National Rural Health Mission (NRHM) of the Government of India, which calls for such a cadre, supported by a strong primary based referral system, to be created across the country.

The validity of community approach has been demonstrated by SEARCH (the Society for Education, Action and Research in Community Health), whose work in training village health workers in neonatal care they say has brought down the infant mortality rate from 120 to 30 per 1 000 in their project area in Gadchiroli district of Maharashtra. Their evidence was so convincing, the NRHM incorporated it as a key policy recommendation. The Indian Council of Medical Research is also currently testing it as a pilot project in five north Indian states.

The NRHM policy requires individual states across the country to implement this kind of approach – one that is rooted in Indian experience and reality. But Goa has not yet put such a programme in place, admitted Goa’s Director of Health Services, Arvind Salekar (now retired).

The anganwadi

One element of Goa’s health system that does seem to be working well is its ‘anganwadi’, a network of localized crèches that are part of a nation-wide programme. The ‘anganwadi
workers in identifying children with learning disabilities or
dealing with child sexual abuse, said Lourdes Miranda.

Martha Mascarenhas, a senior official of the Integrated Child Development Services in charge of Salcete taluka, said a new innovative dimension to Goa's Integrated Child Development Services [ICDS] programme has been nutrition education camps for adolescent girls, including school dropouts and young women, in the 14-45 age group. Here they are taught the importance of nutritious food along with cooking demonstrations emphasizing low cost and locally available food with an emphasis on salad recipes. At these camps issues such as relationship problems are discussed and vocational training skills related to tailoring, catering and craft are taught.

The Goa government is expecting the anganwadi worker to play the role of the ASHA worker. But as shown elsewhere in the country, she is heavily over-worked with her present responsibilities in running a crèche and monitoring malnutrition in children. Taking on the role of community health worker in preventive and curative work, adhering to targets imposed by various health programmes and so on would place a huge work burden on her. Hence the simple necessity to have a cadre of trained, locally based health workers.

But with successes like the anganwadi in their allotted role, and of ASHA workers elsewhere in reducing infant mortality, and the many other community experiences throughout India which have been proven by people of both dedication and science, the bottom line seems obvious: the community – there is where India's health can and should begin.

Research has a role in developing our ability to see the wider picture, confirm results, and pinpoint linkages. Sharing these insights with the wider community would help to create a common pool of knowledge and experience that can be drawn upon by individuals and groups to better understand their own dilemmas and in their work for social good.

When I visited an anganwadi in Madrekarwada in Bicholim town, there were 45 children registered on the muster roll. The state provides a rich fare of ragi (finger millet), which is sprouted and roasted, gram flour (ground chick peas), groundnut, jaggery (unrefined sugar), dried green peas, mung (sprouted beans), rice and ghee (clarified butter).

Supplies are received regularly, said Lourdes Miranda, the anganwadi worker. Packets of dry supplementary food are prepared by the anganwadi workers and delivered to the homes of all pregnant and lactating mothers as also to infants from six months to two years of age.

Children attending the anganwadi, though cramped into a small rented room, are fed a nourishing mid-morning snack cooked by the anganwadi helper. Sprouted mung usal (mung bean curry), misi roti (a Rajasthani bread), rice idlis (rice with dal), groundnut ladoo (a sweet), kabuli chana (a chickpea dal) and mixed ladoo (sweets), are on the weekly menu. The idlis offered to me that day were fresh and delicious. The children are obviously at home and comfortable with their teachers and entertain the visitor with action songs and stories. Such supportive care for young children has clearly been a boon to rural women, particularly those working in agriculture.

Other states that only offer calorie support through khichdi (rice and lentils) through their anganwadi programme, could draw inspiration from Goa's commitment to the health of its children. The Goa government should additionally consider support for a kitchen garden that provides fresh green vegetables and fruits for the children. Maintained by the community, it would further enhance the need for micronutrients that enhance immune status, and ensure against leakages and corruption, which is commonly seen in other states.

A doctor visits the Bicholim anganwadi once a month. The anganwadi workers are able to administer oral rehydration treatment to diarrhoea cases and refer those that require medical attention. The contribution of these anganwadi workers to the community, both in Bicholim and in Madkai, where I had an opportunity to observe their work, is incalculable.

The efforts of Sangath have helped to sensitise anganwadi workers in identifying children with learning disabilities or
There are very simple diagnostics that can be done, said Sadikot – like checking for maculopathy (macular decay, a diabetic complication which leads to blindness in the central part of the eye) with a simple eye test card.

“And we have the Jaipur foot, for amputees. A good foot costs US$ 8 000. But a modified Jaipur foot costs US$ 25-30. Why can’t India establish 20 centres to provide them across India?” Sadikot asked.

But these things are not being implemented “because chronic diseases have not come into the focus of the ministry… India spends 0.9% of its expenditure on health. Less even than Mali. For a country like ours it’s absurd”.

• As for research, “We keep doing these studies, and after that no-one takes it on”, Sadikot told EAGLES. “And imagine I’m the minister. Even if I want to take on diabetes management and prevention, the effects won’t show for 10-15 years, and I know I’m not going to be in still the job. If I were the health minister – or the finance minister – I know I’m going to face an election in five years, so I’m going to do something that gives me mileage right now, like being seen giving polio drops to people and all those things.”

“70-80% of the cost is born by the patients themselves. And 40% of our population earns less than US$ 1 a day… I’m on the Insulin Task Force, and we still have insulin available, with one vial containing 400 units. It’s cheap because two or three Indian companies began making it and the prices definitely fell. It’s not cheap enough for a very poor person, but in the type of society that we have, Diabetes India is able to give free insulin to poor children.”

• Thus India’s prime need, according to Sadikot, is to identify what communication campaigns would be effective. “Absolutely. And for the doctors. I’m a physician. We don’t want complex information – we want to know simple things. A patient walks into my clinic with high blood sugar. What do I do? How do I adjust doses? What do I look out for? We have enough studies now! When are we going to get out of that academic loop?”

• And there’s more…

Diabetes physicians and NGOs in developing countries come up with many, simple proposals for practical products that if they were available to them, would make a great difference. All that’s needed is to ask. Here are just two more recommendations that were proposed during our investigation: develop, produce, and make available low cost strips for blood glucose testing.

Develop, produce, and make available low cost safety devices for the ‘sharps’ used in blood tests and insulin injection.

And existing cheap technologies need to be shared globally, such as: ceramic pots, with water, underground in a very cool place, can be used to store insulin safely. [It must be kept below 30ºC to remain active.] A two-skin pot has been developed by diabetes NGO, the DREAM Trust, in India. Similar pots are used in Tanzania. 

Watch out, ‘global health aid industry’!

Later this year, the Global Health Watch 2 (GHW2) will be published. True to its strap line of being an ‘alternative world health report’, a large part of GHW2 will consist of a report on the performance of the global health community in responding to the world’s challenges. Among the many chapters are ones on the global health landscape, the WHO, the World Bank’s health strategy, US foreign assistance in the health sector, the Global Fund, and perhaps most interestingly, on the Gates Foundation.

The book will not pull its punches in criticising the massively inflated global health aid industry that remains poorly coordinated, inordinately top-down in its orientation, and largely unaccountable. Other chapters likely to catch the eye include a chapter outlining an alternative development paradigm for health; a chapter on the growing securitisation of health; a chapter highlighting the scandalous neglect of governments and donors towards improving basic sanitation services; and a chapter discussing the relevance of terrorism to health.

The secretariat of GHW consists of the People’s Health Movement, Medact and the Global Equity Gauge Alliance.

David McCoy, David Sanders and Antoinette Ntuli, Managing Editors, GHW
Africa Malaria Day on 25 April manifested an increasing commitment of resources and political will to combat malaria in the continent. The WHO’s new Position Statement is now urging all parties to “purchase only long-lasting insecticidal nets (LLINs)”, the most cost-effective antimalarial intervention, with a view to full coverage of all those at risk of malaria. Hitherto, antimalaria efforts have been focused on a target group comprising under-5-year-olds and pregnant women, with insecticide-treated nets (ITNs) averting 50% of malaria cases and reducing all child mortality by an average of 18%. Yet, despite excellent progress in saving infants’ lives, the bednet numbers do not add up.

UNICEF procured 69 million bednets between 2003-2007 at a cost of US$ 298 million, plus 37.2 million insecticide kits for retreating nets. This includes 55 million LLINs at an average cost of US$ 4.91 each. Over 80% of nets were for sub-Saharan Africa (SSA). Latest figures from the Global Fund to Fight AIDS, TB and Malaria indicate the Fund has distributed 46 million LLINs, mostly in Africa, since 2002.

Meanwhile, WHO reports that, according to figures from African governments, at least 50 million new ITNs, along with 7.77 million re-treatments have been deployed between 2000-2006. It would therefore seem that, as significant numbers of bednets already existed in SSA, and allowing for some double accounting, there are around 100 million ITNs in Africa.

According to latest UNICEF data, the 376 million population in SSA includes around 125 million <5-year-olds who, together with pregnant women, constitute the primary target group. Yet, only a paltry 8% (or around 10 million) of the targeted children sleep under an ITN.

This sorry picture is reflected in a recent study that identified, using data from 1999-2006 from 43 SSA countries, a combined total of 133 million under-fives and pregnant women in the SSA target group. The survey found ITNs in only 6.7% of homes and that a meagre 16.7 million ITNs existed in the 123 million at-risk households. The authors calculated that, to meet the 80% coverage by 2010 figure agreed by the 2005 World Health Assembly, some 130-264 million ITNs would be required (their best estimate being 192 million, assuming that 55% of nets were used by the target groups).

Management consultancy experts have also produced a report, prepared by Malaria No More and McKinsey & Company for the Roll Back Malaria partnership. Released in January and based on 30 countries in SSA (which account for 90% of both malaria deaths and incidence in Africa), it concludes that 68 million LLINs will be needed annually for the next four years to achieve 100% coverage – at a cost of US$ 3.4 billion over five years. Under their ‘business case’ scenario, LLIN coverage should reach 57% of the primary target group in 2012, up from the current 20% (although no source for the current figure was given).

The report further indicates that nets will need to be replaced after their 3-5 year lifespan, despite evidence that some nets, specifically Sumitomo Chemical’s OLYSET® net, function adequately even after seven years in African conditions. The longer-lasting nets are far more cost-effective, using a 7-year net the estimated cost per child death averted is US$ 104, assuming that the net purchase cost is US$ 5.50, whereas an LLIN lasting only 3 years (costing US$ 4.50) would equate to US$ 212 per child death averted.

Despite all the good news and comprehensive, multidisciplinary action to combat malaria in Africa, the crucial questions remain; where have all the bednets gone and who is using them? Why do only 8-20% of the target group sleep under an ITN? Moreover, if less than 17 million nets are available in the 123 million households targeted, what has happened to the rest of the tens of millions of nets that have apparently been distributed?
WHO’s Global Malaria Programme is now recommending “full coverage of all people at risk of malaria” using LLINs. Without an understanding of what has happened to the millions of bednets already disbursed, the lives of hundreds of thousands of infants, future investments and the recently mooted goal of eliminating malaria by 2050 are all in grave jeopardy.

Perhaps of even greater import is the fact that real-time data collection is needed in all major interventions, so that policies and activities of a global nature can be based on current evidence, not on data that is — apparently — out of step with the real situation. Reliable mechanisms to obtain that information and make it widely available must be the responsibility of those driving the bednet programmes. We need good evidence on the true social acceptability and actual application of LLINs in Africa, and understanding of their impact and what may be serious social obstacles to the whole programme, in order to overcome them and achieve the goal of preventing the deaths of up to a million infants.

---

Statement of interests
The author hereby declares that he has no conflict of interest.

For further information, please contact Andy Crump:
acy@mac.com

---


Miller, J.M., et. al. (2007) Estimating the number of insecticide-treated nets required by African households to reach continent-wide malaria coverage targets. JAMA 297; 2241-2250


---

**Malnutrition and food security: creating ‘appropriate GM’ for the poor farmer**

> by Mike May, Marc van Montagu

The Institute of Plant Biotechnology for Developing Countries (IPBO),
Gent University, KL Ledeganckstraat 35, B-9000, Gent, Belgium.

**S U M M A R Y** • A global food security crisis is underway. Driven by an increased demand for livestock feed, an increasing population, arable land shortage and climate change, and biofuel policies, cereal reserves are at an all-time low, whilst food prices are escalating. The International Assessment of Agricultural Science and Technology for Development² says GM crops “in their current form” will give unreliable benefit to the poorest. Despite this, technologies for the improvement of crop nutritional quality - and yield - rest unused, and a new unquestionably pro-poor GM is waiting to be developed by international and national public laboratories. Why is this, and what must be done?
For those of us with the luxury of an education and the resources to take informed actions about what we eat, the consequences of dietary deficiencies in essential minerals and vitamins are unimaginable. Yet, for those many millions around the world living below the poverty line, where food is the most important daily expenditure, malnutrition is the one of the largest causes of morbidity and premature death. For the poor and food insecure, malnutrition causes 53% of deaths in children below the age of five of which, an estimated 500 000 die each year because of vitamin A deficiency alone. For the two billion people that are deficient in iron, the two billion deficient in zinc and the 1.5 billion that are deficient in iodine, their lower cognitive ability, lower work productivity, impaired growth and impaired reproductive capacity further restrict their prospects of escaping the poverty trap.

The rural poor, where 75% of the malnourished live, bear the brunt of this suffering since their diets consist predominantly of micronutrient deficient staple cereals such as wheat and rice. The situation could in fact be far worse had it not been for the remarkable technological breakthroughs in cereal productivity of the “Green Revolution” of the 1960’s. Quite rightly, Norman Borlaug, the father of this international effort was awarded the Nobel Prize for Peace in 1974 for the millions of lives that were – and continue to be – saved from hunger. Since then, continued advances in cereal productivity through breeding – and more recently plant biotechnology, the emergence of an organised seed sector, improved seed quality, irrigation and fertilisers have continued to drive down the price of wheat and rice to levels that are within the reach of the poor.

Whilst the Green Revolution provided a temporary solution for the calorific requirements of certain parts of the world, what it did not do, however, was to impact the nutritional quality of staple crops. If science and technology could revolutionise improvements in caloric content so eloquently, are there similar prospects for tackling the crippling burden of malnutrition?

The answer is yes, and the solution, bio-fortification, is technologically within our grasp. Indeed, plant scientists had already identified the appropriate tools to achieve this goal before the turn of the century, and today, there is a veritable cornucopia of genetically modified cereal varieties enhanced in iron, zinc, biotin and vitamin A content, and varieties with yield improvements. Even varieties carrying recombinant vaccines have been characterised in considerable detail. For example, a single 100g serving of “Golden Rice”, genetically engineered for the overproduction of vitamin A, would provide the daily recommended dietary intake of this micronutrient for a child.

This approach makes eminent sense: it targets the poor who survive on a cereal-based diet, it is rural based, where 75% of the malnourished live, it is cost-effective since the supporting breeding programs and seed distribution networks can be replicated across countries, and it is sustainable. Apart from the upfront research costs, this approach should also circumvent the recurrent annual costs incurred in alternative programs of bio-fortification based on the provision of synthetic dietary supplements.

Of course all such potentially beneficial technologies will need to be tested in local conditions, to assess their full impact on the poorest – not only nutritional but also economic, social and environmental. These would be something like Phase IV clinical trials of new pharmaceuticals. Moreover, we can and should be prepared to learn from such local field experiments, which means being prepared to adjust the technologies to take account of all impacts, or even abandon them, or to create new ones that are fully appropriate.

All GM means is make full use of the molecular mechanisms that are life itself, and not simply to neglect the exponentially growing knowledge that biologists have of how those mechanisms work. Why not bring that tremendous knowledge to the real and total benefit of the poorest? ‘Appropriate GM’ is entirely within our grasp.

Why then, are such life-saving technologies not reaching the farmers who desperately need them, particularly when prevention, rather than cure, is surely the most economically and socially acceptable course of action? Perhaps more importantly we should ask how many lives have been lost because of the delays?

The answer lies in part in the desperately slow implementation and costs of national and international biosafety regulations for the use of genetically modified organisms (GMOs), particularly those relating to the Cartagena Protocol on Biosafety (CPB) of the Convention on Biological Diversity (CBD). We need biosafety regulations to safeguard human and environmental health. At the same time, these regulations must be framed within the vast body of scientific evidence obtained since the first commercial release of a handful of genetically modified crops in 1996. That evidence has proven the societal, economic, environmental and health benefits that have accrued to the producers and consumers of these crops – and shown no recorded adverse health effects; on the contrary, in the case of the Golden Rice, the benefits to reduce Vitamin A deficiency with all its drastic consequences are evident.

The consequences of the delays in the implementation of these regulations and the protracted and irrational debate
surrounding the perceived risks associated with GMOs has led to an escalation in the costs of regulatory approval packages that prevent the public sector and developing countries from bringing the benefits of scientific advances to consumers.

Regrettably, because of this, genetically modified, bio-fortified cereals and crops with significantly improved yield (such as a rice with double the yield of the Green Revolution varieties), improved use of fertiliser, drought tolerance and resistance to pests and diseases remain blocked in the pipeline. The vast majority of the countries that would benefit most from these scientific advances suffer both from a lack of capacity to formulate appropriate biosafety laws, and are heavily influenced by misguided campaigns of misinformation – originating largely from food-secure countries and regions such as Europe. For example, Egypt has delayed cultivation of GM insect-resistant potato over fears of losing the export market to Europe – despite the health and environmental benefits that would ensue from a reduction in the huge use of insecticides in Egypt.

What then can be done to improve this situation?

Firstly, of utmost importance is to fast-track approvals and mechanisms (such as investment in quality seed production and distribution systems) so we can test for the full value and impact in local conditions of those genetically modified, locally adapted plant varieties presently blocked in the pipeline that appear to have clear and unambiguous humanitarian value (such as Golden Rice), in much the same way as we adopt special regulatory procedures for the approval of orphan drugs. Given success in the local trials, the parallels between the two scenarios would be compelling. Tackling micronutrient deficiencies though the local production of staple food crops in reliable supply, and of enhanced nutritional quality, promise to raise the undernourished from abject poverty – through significantly alleviating the morbidity associated with their condition. The up-front costs of such a large-scale endeavour, although considerable, would be insignificant compared to the hundreds of millions that must be spent annually on the distribution of dietary supplements. This raises an interesting scenario wherein the finance allocated to dietary supplement distribution programs, since it would no longer be needed, could be diverted into programs for the local research, testing and multiplication and distribution of micronutrient-enhanced crop varieties.

Secondly, to sustain the future introduction of new varieties of better yield and of more balanced nutritional composition, the public sector research institutes that generate the bulk of the innovation behind these advances must be empowered to engage in appropriate research using GM tools. A much more participatory approach to experimental design, involving all stakeholders in potential products, is needed – to ensure that it is demand driven. This is particularly true for those in the developing countries. This implies a multitude of factors:

- The ‘post-genomics’ era is producing technologies of increasing sophistication at increasingly reduced cost. What was scientifically inconceivable ten years ago is now entirely plausible. Increased finance for programs in the public sector targeted towards the enhancement of yield, disease resistance, nutritional quality and drought tolerance should be given priority.

- International co-operations must be financed in such a way that the knowledge derived from these activities can be transferred to developing country scientists for

Green revolutionary’s goals for a pro-poor GM

MS Swaminathan, who played a leading role in India’s Green Revolution, which increased food production but exacerbated income disparities because of the need for good irrigation, fertilizers and credit, now works through his Research Foundation to apply science to broad goals in sustainable development, including efforts to eliminate food, income and gender disparities, publishing last year “Food Insecurity Atlases” of both rural and urban India.

Swaminathan told RealHealthNews:

“An appropriate GM should be pro-nature, pro-poor and pro-women. The bottom line of India’s Biotechnology Regulatory Policy should be the economic well being of farm families, food security of the nation, health security of the consumer, protection of the environment and the security of national and international trade in farm commodities”.

> READ ON

MS Swaminathan Research Foundation
http://www.mssrf.org/about_us/about_us.htm

Food Insecurity Atlases of Rural and Urban India
http://www.mssrf.org/fs/atlas/rural.htm
http://www.mssrf.org/fs/atlas/urban.htm
the accomplishment of locally relevant crop improvement programs.

- We need mechanisms to empower developing country scientists, and enable them to participate in – and contribute to – the global knowledge-based bio-economy that is emerging.

- Developing country scientific institutions and international organisations that pioneered the Green Revolution such as the centres of the Consultative Group for International Agricultural Research (CGIAR) must play a critical role in the design and execution of these programmes.

- Support must be given to breeding programs and quality seed production systems in the developing countries, where a strong seed industry does not exist, and where the public sector is the major player.

- Regulatory compliance and biosafety regulations must be brought into line with appropriate scientific evidence, regarding risk and benefit, and reduce the costs of these procedures.

- We must promote the participation of public sector scientists in the negotiations of the CBD and CPB to ensure that their voice is heard (a forum to enable this is already in place – the Public Research and Regulatory Initiative)\(^5\). Through such initiatives and training programs, we could build capacity in biosafety regulations and intellectual property law in the developing world.

- The emergence of small to medium sized enterprises (SMEs) that are essential for capturing value from public sector knowledge, should be encouraged through policy measures that stimulate investment;

- Public-private partnerships that allow scale up of technology and that stimulate creative approaches to licensing for humanitarian purposes (such as the Agricultural Biotechnology Support Project II)\(^6\) should be encouraged.

Thirdly, overarching all of this, we must encourage a more participatory, multistakeholder approach towards setting priorities for food security and nutrition crises that are already upon us. This must be led by political wisdom drawn by joint consensus from the relevant ministries of health, agriculture, finance, environment, and trade. Radical changes in the way science is done on an international basis, the way in which biosafety regulations are implemented, and a new spirit in co-operation is required if the benefits of science are to reach those who need them the most.

This has been eloquently summarised by Joachim Von Braun, Director General of the International Food Policy Research Institute\(^7\) earlier this year:

“World agriculture has entered a new, unsustainable, and politically risky period. Agriculture – and the natural resources it depends on – has been overexploited ecologically, has suffered from underinvestment, has recently been exposed to ill-designed bioenergy programs, and has been politically sidelined for too long. It is now at a critical point. Appropriate responses to the food and agriculture price and productivity crises are lacking. A global initiative for accelerated agriculture productivity is necessary now; such an initiative makes economic sense, is pro-poor and sustainable, and serves security. The initiative needs political leadership and coordination. There is no effective governance architecture at the global level and national levels to address the matter. Industrialized economies, including the United States, should substantially accelerate their investment in international agricultural research and development (R&D) in cooperation with new players”\(^8\).
BAMAKO MINISTERIAL FORUM AIMS TO BE INCLUSIVE
Meeting of minds on a new philosophy: research for health

Participants from across the spectrum of research, health and civil society are being invited to take part in a landmark conference in Bamako, Mali.

Up to 1000 participants will be invited to the Global Ministerial Forum on Research for Health in Bamako, Mali, on 17-19 November 2008, which is co-organized by six partners: the Council on Health Research for Development, the Global Forum for Health Research, the Government of Mali, UNESCO, WHO and the World Bank.

The world wide call for abstracts for the conference has already closed. But researchers, health professionals and NGOs can still make inputs through consultative questionnaires in English and French on the Bamako2008 website. Responses and views expressed will be synthesised and published.

The Steering Committee and Programme Committee will finalize the programme and list of invitees in the near future. WHO has already sent invitations to all ministers of health of Member States world-wide, while UNESCO has invited ministers of science and technology, higher education, research, social development and culture. Certain ministers of foreign affairs and development co-operation will also be invited.

The philosophy behind the Global Ministerial Forum stems from the need to broaden perspectives on health research from their current, largely biomedical, emphasis towards a recognition of the intersectoral nature of global health challenges. While climate change, rapid urbanisation, and urgent questions of food and water security are threatening the health of many, we can draw great hope from the pace at which scientific, technological and social innovations have transformed our world. However, this transformation is coming about unevenly and inequitably. Consider the fact that the USA has some 2 700 scientific researchers per million inhabitants, while Africa has on average around 70. Hence there is urgency behind the new political momentum for strengthening research and innovation capacity in Africa, and in other developing regions.

Innovation, research and economic development are inextricably linked. Improvements in people’s health, well-being and life expectancy come about not only through the discovery of new diagnostics, drugs and vaccines, essential as these can be, but also through innovation in many other facets of life. Capacity to do research brings with it the capacity to think creatively, to adapt, to examine and analyse, to monitor and measure, and to find innovative solutions that work in a given context.

The Global Ministerial Forum in Bamako will be a significant milestone in tackling crucial questions regarding research policies, research partnerships and research systems, and thereby strengthening research for health in countries worldwide. This high-level event will provide opportunities for in-depth discussion and debate among ministers, major funders, leaders in research, and civil society organisations – on innovating for better health, among even the poorest populations.

The preparatory process for Bamako 2008 includes various regional meetings, the first of which took place in Tehran last November, and the second in Copenhagen on 29-30 April this year. Subsequent meetings will be the Pan-American Interministerial Round Table in Geneva; the Asia-Pacific Preparatory Meeting in Bangkok on 10-12 June; and the Ministerial Conference on Research for Health in the African Region, Algiers, on 23–26 June.

Expected outcomes from Bamako 2008 include specific commitments of resources by key stakeholders; greater engagement with civil society and accountability on the part of key actors and organisations; and the development of a detailed Bamako Plan of Action. ■ BY ANIA GROBICKI

Ania Grobicki heads the Secretariat for Bamako 2008.

Further information:

Opinion papers are invited from informed sources, especially from researchers for health – and policy-makers – in developing countries.

They should be short, well-founded arguments and opinions on matters of significance to health policy and research for health for the poorest.

All our stories and more, in some cases extended and with links to web resources, can be found at www.realhealthnews.net

Editor: Robert Walgate, London, UK.
Designer: Lisa Schwarb, Lausanne, Switzerland.


Our goal is to connect the worlds of research, health policy, and action for the health of the poor and marginalised, with stories that help to promote evidence-based health care for these communities.

This issue of RealHealthNews was supported by our RealHealthProvider, the Alliance for Health Policy and Systems Research, and funds remaining from our 2004-7 support from the Global Forum for Health Research. RealHealthNews thanks the Global Forum for its seed funding.

We now seek new supporters – our RealHealthProviders – and welcome their recommendations on subjects to cover. Interested parties should contact the Editor, Robert Walgate, by emailing: walgate@realhealthnews.net

Support does not necessarily imply agreement with the content or presentation of the magazine. RealHealthNews is editorially independent.

Further information: walgate@realhealthnews.net