Issue 11 ■ October — December 1997

COHRED

Research into Action

The Newsletter of the Council on Health Research for Development (COHRED)

IN THIS ISSUE

The Chagas Disease Saga,

OR THE FUNDAMENTAL IMPORTANCE OF RESEARCH IN IMPROVING HEALTH

IN AUGUST 1909, THE FIRST ISSUE OF THE JOURNAL OF THE OSWALDO CRUZ Institute in Rio de Janeiro carries a paper entitled *Ueber eine neue Trypanosomiasis des Menschen* (On a new human trypanosomiasis). The author is a 29-year-old researcher, the Brazilian scientist Carlos Chagas working at the Oswaldo Cruz Institute. His paper in the journal *Memórias do Instituto Oswaldo Cruz* draws attention to the social, economic and public health relevance of the disease he discovered, and is one of the seeds from which will spring a whole school of thought and research which continues to profoundly influence Latin American science to this day.

It is the beginning of the saga: the discovery of American trypanosomiasis. How could this major medical discovery happen in a poor country in the tropics?

> The 'impossible' can happen — Do not underestimate the capacity of developing countries to identify and manage their own health problems

A look at the role played by the Institute, which was created by the Brazilian Government in 1900 to fight endemic diseases, and that of its director, Oswaldo Cruz, will make it clear how this 'miracle' could come about.

❍ Oswaldo Cruz spent some time at the Pasteur Institute in Paris, and became convinced that the Pasteurian philosophy of combining strategic research, development, production (e.g. of sera and vaccines) and education of young researchers in a single institution would be the key to success. In modern-day terms, Oswaldo Cruz converted

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Saga ... *continued from page 1*

to a firm belief in a scientific research system;

- By propagating the role that science ought to play in the development of Brazil, Oswaldo Cruz managed to win and receive support from the highest political level (the country's President); nominated as Director of the Federal Department of Public Health, he could efficiently fight the diseases that were devastating Brazil's economy, in particular yellow fever and plague;
- Having acquired national leadership, he was in a position to mobilise the funds needed for building up a top-quality institution, whose architectural splendour attracted and attracts the curiosity of the lay person, thus facilitating another of his primary goals: legitimising the role of science in society;
- Very early in the life of the Institute, after his first successes against yellow fever epidemics, Oswaldo Cruz was able to attract the collaboration of scientists from developed countries, who came to visit and work in Rio de Janeiro, interacting with the team of young Brazilian students and researchers recruited to work at the Institute;
- Access to information was always one of Oswaldo Cruz' priorities; with the funds he managed to raise, either directly from the government or through the selling of sera and vaccines, he started to build up a very complete biomedical library, acquiring whole collections of contemporary periodicals, some of which dated back to the 18th century.

Ninety years later, when we are still discussing the role and the place of health research in development, it is surprising to note how many of the principles and factors underlying today's proposed policies and strategies were already present in a poor country at the beginning of the century.

Why then, one may ask, did it take until the 1980s to fully disclose the extent of this scourge and until the 1990s for vector transmission of Chagas disease to be virtually eliminated in Brazil? Was it lack of scientific evidence?

Over this long period, important information was accumulating as the result of laboratory, clinical, epidemiological, socio-economic and applied field research studies, followed by large-scale mapping of the disease's prevalence and its social impact in the American continent. Based on country-wide surveys carried out in the 1980s, using standardised protocols, the overall prevalence of human *Trypanosoma cruzi* infection was reliably estimated at 18 million cases in 21 endemic countries, with 100 million people (25 per cent of all the inhabitants of Latin America) at risk of infection. (According to World Bank 1993 data, Chagas disease ranks first among the tropical diseases in Latin America).

Clearly, the evidence was there. So why didn't it lead to action, i.e. control of the disease?

Solid research findings and sound scientific evidence per se are not enough to establish or impose political priorities

Chagas disease affects mainly poor rural areas which traditionally receive little or no political priority. But, unlike many other parasitic diseases, it can be controlled by eliminating the vector insect that transmits it, mainly by using insecticides and improving housing.

Encouraged by the results of their field trials carried out in 1948 at the Bambuí field station of the Oswaldo Cruz Institute, which showed the efficacy of organochloride insecticides against domiciliated triatomine bugs, the two researchers E. Dias and J. Pellegrino cabled to the Brazilian Ministry of Health suggesting that the disease could be eliminated throughout the territory. Was this discovery powerful enough to mobilise the political forces of the nation? Unfortunately it was not.

Transforming research into action, researchers into policy-makers

In spite of the heavy burden of the disease, and although the appropriate technology for fighting the disease's vector transmission was available, only isolated actions were taken between 1950 and 1975.

A radical change and a major shift in priority came about in the 1990s, when top-level political decisions in six Latin American countries created the Southern Cone Initiative. What where the major forces and factors that promoted this change?

Health researchers must meet, share their findings, doubts and uncertainties, discuss the constraints on their work and on public health issues, raise public consciousness — and eventually become policy-makers: a very efficient short cut to the long road needed to transform research into action

A small ten-person round table was organised by the National Research Council of Brazil (CNPq) in 1974 to discuss certain problems in the study of *T. cruzi*, notably the development of a common protocol to better cultivate this parasite in the laboratory. It was resolved to call a second meeting, in one year's time, to evaluate progress made. Thus were born the Annual Meetings on Basic Research on Chagas Disease in Caxambu (the latest, 24th, Meeting took place last November) and the Annual Meetings on Applied Research in Uberaba (first held in 1984). These have turned into an annual forum where over 700 scientists, research managers and policy-makers meet to discuss science and public health. The meetings helped and are helping to transform research into action in that they sensitise scientific and public opinion and stimulate formation and decision-making.

As in this example, during the military regime, Brazil decided to buy some 15 fighter planes. At one of the first meetings at the Oswaldo Cruz Institute, a scientist working at the Institute presented careful calculations showing that buying 13 instead of 15 planes would save enough

money to finance a nationwide vector control programme that would effectively stop transmission of the disease. He also produced figures showing how many new cases of Chagas disease could have been avoided if such a programme had started immediately after the 1948 work of Dias and Pellegrino. These data became information in the brains and mouths of the participants. Although all the planes were finally bought and no national programme was started, those present at the time realised that something could be done if only one could fight more effectively to win a higher priority for public health problems.

The opportunity came years later when one of the Caxambu scientists became Director of the Chagas Disease Division at the Ministry of Health. The transmutation of researchers into policy-makers, as in the case of this scientist, opened up new perspectives in Chagas disease control and radically changed the priority-setting mechanisms at the Ministry of Health. Finally, research was in action.

Today, Chagas disease is close to being eliminated as a public health problem from all Latin American countries, and the Division of Control of Tropical Diseases at the World Health Organization calls it 'a disease whose days are numbered.'

Chagas disease is a form of trypanosomiasis which is caused by the protozoan parasite *T. cruzi* and usually transmitted by a bloodsucking bug of the family Reduviidae, known as the assassin or kissing bugs. (Editor's note.)

Carlos M. Morel

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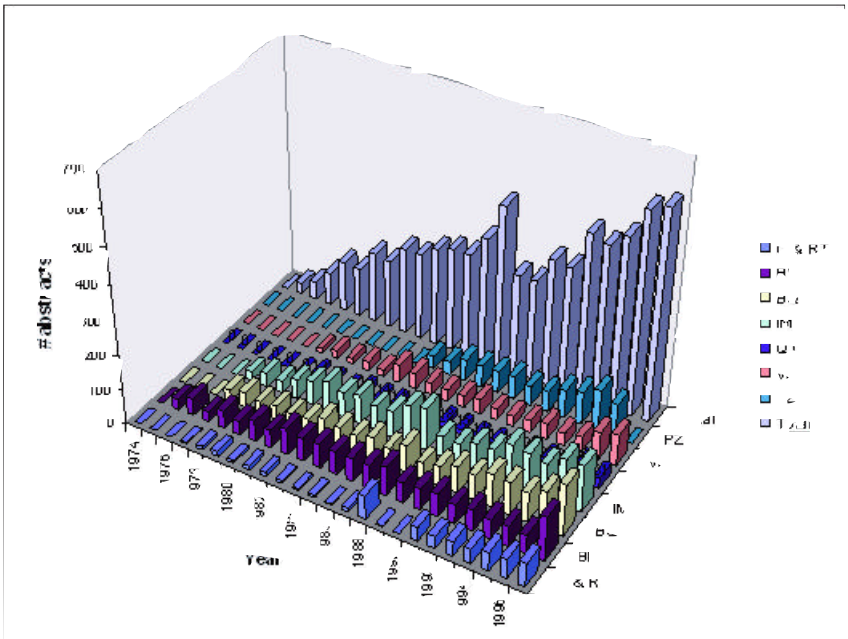
Evolution of Annual Meetings on Basic Research in Chagas Disease



The meetings of 1974 (1st) and 1979 (6th) were held in Rio de Janeiro; all the others took place in Caxambu.
Since 1986, the abstracts are published in the journal *Memorias do Instituto Oswaldo Cruz*.
Abbreviations: **C & RT**, conferences, mini-conferences & round tables; **BI**, biology; **BQ**, biochemistry; **IM**, immunology; **QT**, chemotherapy; **VE**, vectors; **PZ**, protozoology.❑

This article was compiled by Ms Hannelore Polanka, based on the 1997 Ben Osuntokun Memorial Lecture presented by Dr Carlos M. Morel in October 1997 at the annual meeting of the World Health Organization's Global Advisory Committee on Health Research

COHRED, ALLIANCE AND GLOBAL FORUM SIGNAL READINESS TO STEER ENHR FROM TRANQUIL SEA OF PHILOSOPHY INTO ROUGH WATERS OF ACCOUNTABILITY, RESOURCE FLOW ANALYSIS AND RESULTS MONITORING

THE KEYWORDS WHICH DOMINATED THIS year's deliberations of the COHRED Board — analysis, input-output monitoring, coordination, communication — reflected the expectations of the ENHR stakeholders, as well as COHRED's and its partners' determination to bear witness to the strategy's viability and its power to rally a diversity of actors around a common concern — EQUITY IN HEALTH.

To prepare the ground for these tasks, the Board—joined in its discussions by the Executive Secretary of the Global Forum for Health Research (Global Forum)*, Mr Louis Currat, and the Chairperson of the interim board of the Alliance for Health Policy and Systems Research (Alliance)**, Professor Anne Mills—decided to create a Task Force on Critical Indicators (chaired by Dr P. Figueroa) and a Task Force on Resource Flows (chaired by Dr J. Sepúlveda). The latter will coordinate its work, which will include the development and testing of an instrument for analysing health research resource flows, with Global Forum representatives.

Within the recently established Task Force on ENHR Competencies, led by Professor M.A. Lansang, Four Working Groups will focus respectively on: (1) Priority Setting (chaired by M.A. Lansang); (2) Research-to-Policy (chaired by S. Chowdhury); (3) Promotion, Advocacy and ENHR Mechanism (chaired by D. Harrison), and (4) Community Participation (chaired by S. Reynolds Whyte).

The Board further established a Committee on Financial and Budgetary matters (chair: Dr C. Morel), and a Planning Group for the proposed 1999 International Conference.

Joining the Board as new members were:
Dr M. Abdullah (Kenya)
Dr G. Kvåle (Norway)
Dr A. Suwandono (Indonesia).
Ms Mina Mauerstein-Bail replaced Mr Tim Rothermel (UNDP), who has been reassigned to Jerusalem earlier this year.

Dr P. Rosenfield, Dr W. Kilama and Dr F. Salamanca finished their terms of office and received expressions of thanks and gratitude from Professor Charas Suwanwela, Chairperson of the COHRED Board. The Board will meet for its Ninth Session in Geneva, in October 1998.❑

*A collaborative mechanism created in June 1997, this initiative has set itself the goal 'to improve the process of health R&D priority setting so as to correct imbalances between research needs and available resources.'

**An initiative born at the International Consultative Meeting in Lejondal, Sweden, in April 1997.

Its tasks are, among others, to promote national capacity for health policy and systems research (HPSR) on national and international issues, with particular emphasis on countries who currently have limited capacity to participate in HPSR.

Editor's note — In our next issue, we will give a detailed overview of the Groups' targets and the respective time frames.

African workshop on 'Making the ENHR Partnership Work'

LAST OCTOBER, OVER THIRTY PARTICIPANTS FROM eleven African countries came together in Arusha, Tanzania, to discuss how to enhance partnership in ENHR among researchers, community representatives, and decision-makers. The attendants included researchers from health policy and development groups from five countries.

After some introductory remarks by several colleagues, small working groups worked on two tasks:

- *Identify and describe situations and issues that inhibit effective and sustainable ENHR partnerships;*
- *Propose specific strategies that could be implemented by country ENHR groups.*

Two categories of issues were identified: issues that applied to all partners, and issues that related to a particular partner group. In the first category, it was suggested that the range of partners should be widened beyond the three usual groups (researchers, decision-makers, and community representatives) to include health service providers, individuals from donor and development agencies, as well as non-government organisations, community-based groups and religious organisations. The challenge of accepting and understanding ENHR applied to all groups. The problem of discontinuity and lack of accessibility, due to rapid turnover and being excessively busy, also applied to all groups. All partners need to be included from the beginning of the ENHR process in order to promote a sense of ownership and to strengthen the potential for collaboration at every step. Other special issues included the importance of gender and cultural considerations, and the influence of political instability on the success of the ENHR process.

Many partner-specific issues were

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THE HUGE AND DIVERSE CONTINENT OF Latin America is facing an uncertain future as it moves towards the 21st century. The gulf between rich and poor is not narrowing, demographic growth is threatening to swamp the megacities, and in all too many countries social welfare does not rate as high as it should on governments' scale of priorities. All the more reason therefore for decision-makers and policy-setters to take great care in establishing research priorities that will prove to be truly beneficial to each nation but also to the region as a whole.

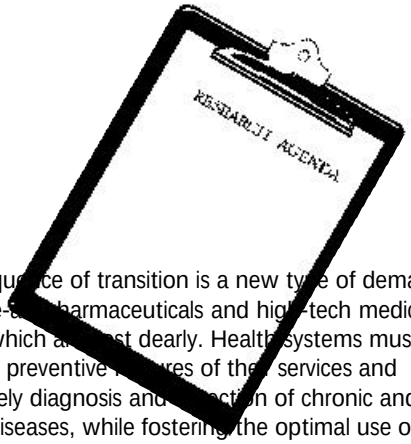
Four specific challenges for the future can be delineated, and no time must be wasted if they are to be met. The first is the health transition, that is, the swiftly changing pattern of health and disease, driven by demographic, economic and social dynamics. The second is the challenge of new and emerging lifestyles which impact on the lives of urban and rural populations alike. The third stems from the pressing need to protect the environment, already heavily under threat throughout the continent. And the fourth is the challenge of poverty; whatever yardstick is used to measure it, the masses of citizens whose earnings are insufficient to satisfy their basic needs represent a destabilising factor.

THE HEALTH TRANSITION

Latin America is witnessing much the same inexorable changeover that developing countries everywhere are experiencing. As the traditional communicable diseases are slowly being brought under control, the countries labour under a double burden from chronic and degenerative ailments. It has long been a truism that more people die from cancer in the Third World than in the wealthy industrialised countries. This change is closely linked with the demographic transition that results from massive population growth, migration to the cities from the countryside, industrialisation and urbanisation.

The countries of Latin America are no exception, as they pass from a population structure of small dimensions, low life expectancy, high mortality and high birth rates and move instead towards large communities with higher life expectancy and lower birth and mortality rates. These demographic changes transform the health and disease profile of the population and introduce a quite different set of risk factors. In some cases the mix of chronic and communicable disease will last for a long time; in others the changeover may be dramatic. Such events as the cholera epidemic which swept Peru early in 1991 may be seen as counter-transitional events.

Overall, the patterns are sufficiently clearcut for the health sciences, for the first time, to be able to predict the sanitary future of a country. The priority challenge must be to reach all social groups on a basis of equitable access both to social opportunities and to a universally available basket of clinical and public health services. Unfortunately,



a direct consequence of transition is a new type of demand for state-of-the-art pharmaceuticals and high-tech medical care, both of which are most dearly. Health systems must strengthen the preventive measures of their services and ensure the timely diagnosis and detection of chronic and degenerative diseases, while fostering the optimal use of first-level health services and promoting more appropriate lifestyles for all. All these trends are pointers towards the direction that health research must take if it is to make a due contribution to the estimation of risks, the identification of cost-effective interventions and the design of health policy.

LIFESTYLES AND WELL-BEING

Besides the measurable changes in epidemiology, the continent is seeing rising morbidity and mortality rates from external causes, such as traffic accidents and urban violence, as well as the soaring toll from smoking, drug-taking, unwise diets and unhealthy lifestyles. Although studies are unanimous in showing direct relationships between tobacco use and lung cancer, diet and cardiovascular disease, sexual behaviour and STDs, a wide variety of approaches have been proposed to counter such risk factors. Latin America's contribution towards determining the right corrective methodologies has so far been almost negligible.

There is a clear need to adopt an active line of research into the risk factors that impact on health, into the identification of high-risk groups of population, and into opinion-generating mechanisms (including the use of television) that may serve to counter family disintegration, illicit drug consumption and urban violence. Such factors as migration, education, nutrition, employment and housing all pose a challenge to research and demand a transdisciplinary approach.

PROTECTING THE ENVIRONMENT

The explosive urbanisation which is creating megacities all across Latin America has potential benefit for those who live there in terms of facilities and services of all kinds. But if those services are beyond the reach of a majority of the residents, such cities become a source of pollution, marginality, violence and infectious diseases. The process has been too fast, disorderly and accompanied by all too little investment in planning for environmental protection. Clean drinking water is rarely available to all who need it, and poor management of human and industrial results in heavy contamination. Air and soil pollution encourage erosion and desertification outside the cities, in addition to the heavy inroads being made into the continent's vast forested areas. As the spectre of global warming looms, the particular fear in Latin America is of the emergence of malaria, dengue, yellow fever and Chagas disease in areas where they did not exist before.

Little research has been undertaken as yet into the effects of pollutants on human health, so the continent is

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Latin America ... *continued from page 5*

ripe for structured epidemiological studies in this field. A special challenge is to find ecologically acceptable and economically affordable solutions to the problems linked with water contamination. Some studies have been made in Santiago de Chile into the health consequences of atmospheric pollution, and these could well be projected to solve problems in other Latin American cities.

Poverty and Exclusion

Two dimensions of poverty are generally recognised: an insufficiency of income, and the lack of satisfaction of basic needs. Some observers add a third dimension in terms of the marginality or social exclusion of poor communities or families. Research so far carried out in Latin America has tended to be country-specific, making it difficult to compare the widely disparate values and social contexts encountered throughout this huge continent. Moreover, because of the different standards and indicators used, such studies as exist often yield insufficient and even contradictory information. Even the estimated numbers of 'poor' in the region range from as little as 70 million to as much as 183 million, depending on which respected authority is consulted. What is generally agreed is that there is a growing urbanisation of poverty (an increase in the percentage of urban poor out of the total poor population), but the dynamics of this process are not yet understood.

While fundamental research is required into what causes and what constitutes poverty in the continent, the issue of ensuring social and political representation of poor populations also calls for in-depth investigation. Applied research is needed into systems for ensuring safe water supplies and waste disposal that are cheap yet effective under different climatic and environmental conditions. And there is much room for research into health care financing, including the different methods of delivering and paying for health services.

A Regional Research Agenda

The goal of earmarking 1% of GDP to science and technology activities has never been attained by any country of the region. While developed countries spend around 2.7% in such activities, in Latin America such expenditures range between 0.75% and 0.24%. Moreover, health rates a low priority within the science and technology field. A review of the 41,000 scientific papers published in six Latin American countries between 1973 and 1992 showed that clinical research represented 53.4% and biomedical research 43.9%, but only 2.7% corresponded to public health research. Little effort is yet being made to identify the different actors involved in health care (politicians, entrepreneurs, clergy, consumers, professionals, researchers) as well as their sources of information, what motivates them to make decisions, and just who constitute their allies and who their competitors. The contributions that epidemiology and social sciences can make to collective health have not been fully recognised.

An important step in the right direction is the project undertaken by GEOPS (Grupo de Estudios en Economia, Organizacion y Politicas Sociales) and supported by COHRED and IDRC. This study group, based in Montevideo, Uruguay, aims to identify the main challenges to health in Latin America over the next 15 years and to pinpoint the health research gaps associated with those problems. In the long term, this project will play a catalytic role when the different countries of the region are setting their health research policies.

Latin America has much to contribute to the global agenda in the field of international public health. This continent already has a high degree of theoretical sophistication and has the potential to re-define organisational and operational models that will match the real needs of countries and truly grasp the scientific, social and political opportunities that lie ahead. But a well-focused research effort is now essential to ensure that a truly analytic approach to public health replaces the worn-out and over-simplified paradigms of health causes and health risks.

***John H. Bland, a former Editor-in-Chief of WHO's 'World Health' magazine wrote this overview for* Research into Action.**

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Arusha workshop ... *cont'd from page 4*

described. Community partners are sometimes underestimated, and misunderstood (sometimes for cultural reasons); they may feel 'used' and left out if they are not included in the discussion and dissemination of research findings. Policy-makers may not understand the need for evidence-based planning; this may be due to poor 'marketing' by researchers. The priorities of policy-makers may be quite different from those of the other partners (community, researchers) with respect to both content and timing. And sometimes there are conflicts among policy-makers themselves, which make effective partnerships difficult to sustain. Regarding the researchers, their experience and perspective is often too narrow, so that they may not realise the valuable contribution which other partners can make to the ENHR process. In addition, researchers tend to fear bureaucratic rigidity.

The workshop groups then proposed several **general strategies** in relation to the issues and challenges which had been identified.

☞ The preparation and use of good information materials, as well as a 'teamwork approach', would address the continuity problem. (*'Teamwork' was understood to mean the way in which a group of colleagues, preferably from different countries, share the work of facilitating the ENHR process in a given country.*)

☞ In order to come to a better understanding of the special contribution community partners can and do make to the ENHR process, it was recommended that focused workshops for researchers and decision-makers be held, where countries could present examples of successful community participation.

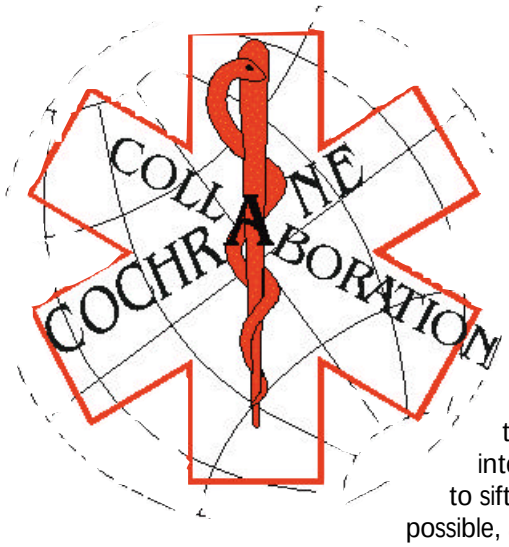
☞ To enhance the participation of decision-makers in the ENHR process, an explicit 'system' should be established. This system would range from regular discussions with key individuals to focused seminars to periodic networking meetings and should include the use of well prepared ('packaged') information materials, such as problem-oriented summaries of research results, inventories of available national expertise and a data base of recent and current research projects.

☞ To strengthen the continuity of the ENHR process, it was recommended that 'prime movers' of ENHR assemble a multidisciplinary team, delegating the leadership of certain aspects of the ENHR process to team members.

The workshop participants believed that if these strategies were put into practice, perhaps in small, incremental steps which focus on the most relevant issues, the result would be good research — broad-based and addressing important national health problems.

Prepared by Vic Neufeld (COHRED Consultant) and Raphael Owor (Focal Point for the African Regional ENHR Network)

For better decisions in health



HEALTH CARE RESEARCH IS PILING UP AT AN astonishing rate, with thousands of health care journals churning out reams of data. Electronic means of storing virtually unlimited amounts of information is boosting the capacity to swamp us with even more. Sorting out the wheat from the chaff and staying up-to-date is critical, but getting harder all the time.

The Collaboration's Mission

The Cochrane Collaboration is trying to provide an answer to one key part of all this by gathering together and analysing studies that consider the effects of health care with the minimal amount of bias possible. The Collaboration is an international effort by researchers, practitioners, and consumers to sift through health care research, find as many controlled trials as possible, analyse them, and make this information as accessible as possible. The aim is to help people to make better decisions in health — whether they are practitioners, consumers, policy-makers, or researchers considering their next projects.

Members of the Collaboration worldwide are trawling through electronic data bases, searching journals by hand, and trying to find as many unpublished trials as possible. This includes going directly to researchers and pharmaceutical companies too. The net is being spread over as many languages as possible, with major searching and translation efforts in eastern and western European languages, as well as in Asian languages. The idea is to find as many helpers and as much support as it will take to leave no worthwhile stone unturned. The Collaboration's register of these trials, called The Cochrane Clinical Trials Register, now has more than 150,000 published and unpublished trials, and it's growing all the time.

Cochrane review groups both help in this effort to identify trials and work in teams to produce systematic reviews of the results of these trials. There are now 50 such review groups looking at all prevention and treatment of all kinds of diseases as well as issues such as effective professional practice and communication.

The Cochrane Library: a treasure-trove

The Cochrane Library, published on disk and CD-ROM four times a year, now includes 276 completed reviews, which will be updated whenever further trials emerge, or in response to readers' criticisms and ideas. About 50 reviews are being added to the Library each quarter now.

The Library holds the register of trials, and a data base of articles on the methodology of reviewing research. There is also a data base pointing readers to more than 1,800 other similar kinds of reviews published in journals. Individuals and libraries can subscribe to the Library. The abstracts of all the reviews are available free on the Internet.

The Consumer Network

The section of each Cochrane review on 'implications for future research' is one of the features that is attracting consumers to this organisation.

> "The aim is to help people to make better decisions in health — whether they are practitioners, consumers, policy-makers, or researchers"

Consumers are actively participating in many parts of the Collaboration — helping to decide its directions, priorities, and products, through to being involved in the production of reviews and helping to spread the information more widely in their communities.

Consumers are helping to define the full range of benefits and problems of health care interventions, to help to consider the available evidence, and making recommendations for future research.

Consumers are also concerned with making these reviews easier to understand — an important part of making information accessible to a wider audience around the world. The Consumer Network in the Collaboration encourages consumer participation, helps consumers to get in touch with each other, and produces information for consumers. This includes preparing quick- and easy-to-read mini-'synopses' of all new Cochrane reviews, and tools such as a research glossary for consumers.

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Hilda Bastian

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A Continent-bridging Organisation

The Collaboration is an international organisation, and welcomes participation from anyone who can spare any amount of time or other help in any aspect of its work. There are 15 Cochrane centres around the globe that can help introduce people to the Collaboration, and link them in to activities. There are seven centres in Europe, five in the US and Canada, and one each in Australasia, South Africa, and South America. You can enter into the Collaboration through a variety of languages, including English, Spanish, French, Portuguese, Italian, Japanese, and Chinese.

The Cochrane Library is currently available in English only, but the abstracts and other information will increasingly be available in a number of these languages.❑

Courtesy The Consumer Network, Newsletter No 2, September 1997

COCHRANE centres around the globe :

Europe 7 centres

USA & Canada 5 centres

Australasia 1 centre

South Africa 1 centre

South America 1 centre

Medical community, social scientists and decision-makers meet in Hungary to discuss challenges posed by health and social inequities

TWENTY EXPERTS FROM CROATIA, LATVIA, Lithuania, Estonia, Poland, Slovakia, Slovenia and Romania, together with invited facilitators representing the international community, attended a Workshop on Inequity and Health: from research to policies which took place in Balatonlelle, Hungary, from November 9 to 14, 1997. The Workshop was organised jointly by Hungary's National Institute for Health Promotion (which is a WHO Collaborating Centre for Health Promotion Development in Central and Eastern Europe), the National Research and Development Centre for Welfare and Health (STAKES) of Finland, and WHO/EURO, with participation of the Council of Europe and the Council on Health Research for Development (COHRED).

The declared aim of the workshop was to examine capacity building in Central and Eastern European countries and the Baltic states for research, policy and action in order to meet the challenges of inequity including poverty, social exclusion, unemployment, migration, homelessness, minority issues, and other important aspects of socio-economic disadvantage.

Another goal of the organisers was to collect from the participants and to discuss several examples of good practice for an equity-based healthy public policy.

Each presentation of issues or cases by key experts was followed by interactive team work and analysis. On the first working day, the workshop reviewed the results of state-of-the-art social epidemiological research into inequity, deprivation and mortality. The next day, the participants started with country by country needs-assessment through group work, and went on to a particular case analysis of challenges for health policy, namely that of the Romany population in Hungary. Research findings, policy issues and examples of good practice were presented by key players and experts. This issue was of special relevance in all the countries because of the human rights issues it raised.

On the third working day, the workshop turned from problem to action. Professor Yvo Nuyens presented and guided a discussion on the concept of Essential National Health Research and the real life, highly political context in which health research is carried out and health policy is made. Dr Eric Ziglio described and explained the policy planning process for health and Dr Peter Makara analysed the preferred lines of action in the promotion of equity in health. Finally Dr Pjotr Mierzewski of the Council of Europe introduced the Council's perspective and approach to the issue.

On the fourth working day, a second case of health policy challenge, that of migration, was presented by Per Spenning from the International Organisation of Migration. The case was discussed in the light of regional trends and its relevance to health. Two other aspects considered that day included the role that primary care could play in enhancing equity in health, and the mental health consequences of deprivation. The final day was devoted to collecting inputs and synthesising them in order to reach a conclusion. Participants and facilitators agreed that the aims of the workshop had been met through this intellectually stimulating and very relevant meeting.

The workshop was a very important step on the road towards Network building which started last June with the regional Workshop to Launch a Central and East European Network on Essential National Health Research, jointly organised by the Hungarian National Institute for Health Promotion, COHRED and the International Forum for Social Sciences in Health. It is the common wish of participants and organisers to follow up these workshops with others so as to increase capacity and firmly establish the network for ENHR throughout Central and Eastern Europe. ❑

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ENHR Asian Regional Networking Meeting

Hanoi, Viet Nam

THE SECOND ENHR ASIAN REGIONAL NETWORKING MEETING, which took place from December 9 to 11, 1997, brought together teams from the following countries : Bangladesh, Cambodia, China, India, Indonesia, Lao People's Democratic Republic , Malaysia, Myanmar, Nepal, Pakistan, Philippines, Thailand and Viet Nam.

The focus of the meeting was on ENHR competencies. These are "know-how's" or abilities that are useful in the process of implementing the ENHR strategy in a country, including promotion and advocacy for ENHR, research priority setting, translating research into policy, community participation in ENHR, and networking.

The countries and their constituents, being the prime movers in the ENHR process, have much to share with other countries in terms of their know-how and experiences in planning and implementing such research. Through presentations and group discussions, participants have been drawing lessons from country experiences which will contribute to the development of more systematic approaches for implementing the ENHR strategy. Where applicable, countries might choose to adapt some of those approaches when they are planning, implementing or evaluating their own strategy. ❑

Contact: Dr Corazon M. Raymundo, President, Tuklas Pangkalusugan Foundation, Inc., c/o Department of Health, Bldg 12, Ground Fl., San Lazaro Compound, Rizal St., Sta. Cruz, Manila 1003, The Philippines. Tel 632-928 2889 • Fax 632-641 3918 or 632-732 6590 • E-mail: <craymund@lagundi.cph.upm.edu.ph> • E-mail address Asian Focal Point: <tuklas@gaia.psdn.org.ph>

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Development in Practice. Oxfam (UK and Ireland). 1997. 112 pages. ISSN 0961-4524
A multi-disciplinary journal of policy and practice, *Development in Practice* reflects a wide range of institutional and cultural backgrounds and a variety of professional experience. It is a forum for practitioners, policy-makers, and academics to exchange information and analysis concerning the social dimensions of development and emergency relief work.
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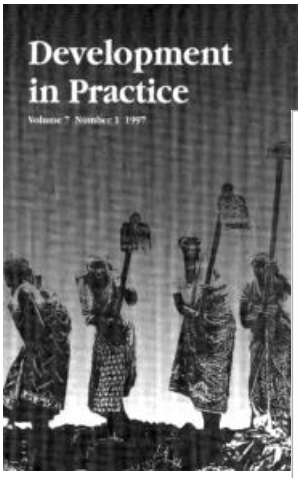
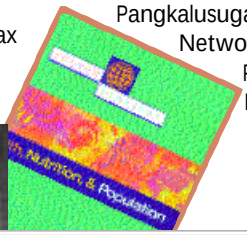
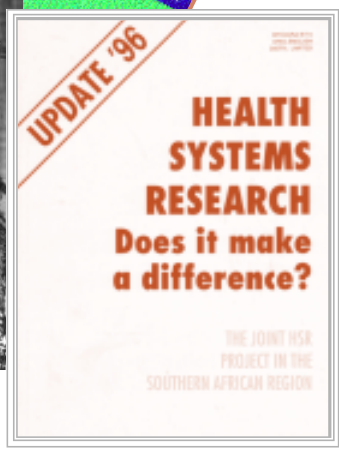
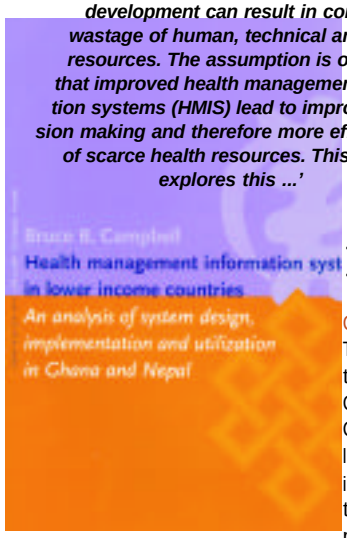




Health, Nutrition, & Population. The Human Development Network, The World Bank Group. Published in the series Sector Strategy papers. 1997. 97 pages. ISBN 0-82 13-4040-9
Prepared by a team of technical specialists from the Health, Nutrition, and Population (HNP) Family of the World Bank's Human Development Network, this HNP Sector Strategy paper presents, with supportive statistical annexes, the development challenges and policy directions in a changing world; the Bank's growing engagement in the HNP sector, and its strategy in that sector. For details: The World Bank, 1818 H Street, NW, Washington, DC 20433, USA. Fax 202-477 6391 • E-mail: books@worldbank.org • Internet: http://www.worldbank.org/



HEALTH MANAGEMENT INFORMATION SYSTEMS IN LOWER INCOME COUNTRIES. An analysis of system design, implementation and utilization in Ghana and Nepal. By Bruce B. Campbell. 1997. 219 pages. ISBN 90-6832-113-7
For details: Royal Tropical Institute, KIT Press, Mauritskade 63, 1092 AD Amsterdam, The Netherlands. Fax 31-20-568 8286 • E-mail: <kitpress@kit.support.nl>
See also our review in *Research into Action*, Issue 7, 1996.



'Poor management decisions in health care development can result in considerable wastage of human, technical and financial resources. The assumption is often made that improved health management information systems (HMIS) lead to improved decision making and therefore more effective use of scarce health resources. This study explores this ...'

HEALTH SYSTEMS RESEARCH: Does it make a difference? Update '96. The Joint HSR Project in the Southern African Region. World Health Organization, Netherlands Ministry for Development Cooperation, Royal Tropical Institute. 1997. 77 pages. WHO Document WHO/ARA/97.5
First published in 1990, *HEALTH SYSTEMS RESEARCH: Does it make a difference?* is intended to bring the concept and the approaches of Health Systems Research (HSR) used by the Joint Project to the attention of health policy-makers, administrators and researchers at the national and international levels. For more information or copies, contact: Professor G. Mwaluko, Manager, Joint HSR Project, WHO Office, PO Box CY 348, Harare, Zimbabwe.

Asian Regional Network Directory. Tuklas Pangkalusugan Foundation. Asian Regional ENHR Network Focal Point (1996-98), Manila, Philippines. 1997. Fax +632-928 2863 • E-mail: tuklas@gaia.psdn.org.ph

Newsletters

Tanzania Health Research Bulletin
Twice yearly 18-page newsletter published by the Health Research Users' Trust Fund (HRUTF). Price per copy US$5.00. Contact: HRUTF, c/o National Institute for Medical Research, Ocean Road, PO Box 9653, Dar es Salaam, Tanzania. Fax 255-51-306 60 E-mail: nimr@costech.gn.apc.org

Joint HSR Newsletter/Journal
This 42-page newsletter/journal is co-produced by the Joint Programme on Health Systems Research (HSR) for Eastern and Southern Africa and the GTZ (German Agency for Technical Co-operation)-supported HSR Project for Reproductive Health & Health Care Reforms in Southern Africa. For details: Fax 263-4-728 998 • E-mail: <mohale@healthnet.zw> or <mwaluko@healthnet.zw>

CCMRC Newsletter
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19th African Health Sciences Congress and joint **Symposium on African Health Priorities of the 21st Century**, organised by the National Institute for Medical Research, in collaboration with the African Forum for Health Sciences. For details: Secretariat, 19th African Health Sciences Congress, National Institute for Medical Research, PO Box 9653, Dar es Salaam, Tanzania. Phone 255-51-30770-31 864 • Fax 255-51-30660-31864 • E-mail: nimr@costech.gn.apc.org

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42nd International Institute on the Prevention and Treatment of Dependencies
'The Changing Face of Addictive Behaviours. Convergence and Divergence,' organised by the International Council on Alcohol and Addictions (ICAA). For details: ICAA, Case Postale 189, 1001 Lausanne, Switzerland. Phone (+41-21)320 9865 • Fax (+41-21)320 98017 • E-mail: icaa@pingnet.ch • Web site: http://www.icaa.ch

COURSES

Amsterdam Master's in Medical Anthropology (AMMA)

Dates: 1998–1999
Location: Universiteit van Amsterdam, Amsterdam, The Netherlands
Contact: Dr Ria Reis, AMMA Programme Manager, Universiteit van Amsterdam, Faculty of Social Sciences, Medical Anthropology Unit, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, The Netherlands. Phone (+31-20)525 2670/2621 • Fax (+31-20)525 3010 • E-mail: amma@pscw.uva.nl
Description: This programme is for students from both Southern and Northern countries, for social scientists working in multidisciplinary research projects in the fields of health and health care, and for physicians and other professionals of health care. The programme takes 12 months to complete on a full-time basis. Four modules are open to applicants who do not wish to follow the full curriculum: *Gender, Reproductive Health and Fertility*; *Chronic Illness*; *Perceptions and Practices*; *Social, Cultural and Historical Dimensions of Infectious Disease*; and *Culture, Psychology and Psychiatry*.

Master of Public Health (International)

Dates: One-calendar-year course, commencing in September/October 1998
Location: Nuffield Institute for Health, Leeds, United Kingdom
Contact: Information and Admissions Officer, Nuffield Institute for Health, 71-75 Clarendon Road, Leeds LS2 9PL, UK. Phone +44-113-233 6942 • Fax +44-113-246 0899 • E-mail: L.Backhouse@leeds.ac.uk • Web site: http://www.leeds.ac.uk/nuffield/id/id.html

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from all of us

to
all of you