

# INCLLEN news

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## Going full circle and beyond

INCLLEN was established more than 20 years ago, promoting clinical epidemiology as a "bridge discipline" between medicine and public health and as a tool for improving effectiveness and efficiency in health care in developing countries. INCLLEN as we know it today has evolved tremendously in response to actual health needs of member countries and global health priorities. INCLLEN is now poised to do much more work in health systems research in the future.

Indeed, INCLLEN has, through the years, expanded its methodological armamentarium to include social sciences, health economics and pharmacoepidemiology. In 1989, the need to link clinical epidemiology with users and producers of health systems research became a main focus of collaborative research. A platform for interaction, the "Bridge" newsletter, was published bi-annually for 10 years to promote these linkages. These interactions have helped to build INCLLEN's capacity in locally relevant health systems research and to increase awareness of knowledge translation as an essential aspect of research.

These efforts have not, however, been sufficient in the face of growing demands on the health systems of developing countries to

address the health problems of the poor. The attainment of the Millennium Development Goals by 2015 is a major challenge for many poor countries. For middle-income countries, the growing burden of transitional diseases and inequities in health threaten to overload fragile health systems. With globalization, emerging and re-emerging infectious diseases require global alert and rapid response systems.

On the other hand, the level of global health resources pouring in to respond to critical health problems has been unprecedented, particularly for diseases like HIV/AIDS, TB and malaria. But on the ground, many developing countries have had to scramble to put order in their houses (health systems) in the face of massive funds for vertical programs.

We have come full circle. The clamor for health policy and systems research (HPSR) again resonates in global, regional and national forums. But the circle has now become more complex and multi-dimensional. Coordinated planning and action, systematic capacity development for HPSR, greater stakeholder involvement and engagement, and global sharing and pooling of knowledge and resources will be required. This special issue of the *INCLLEN News* reflects on HPSR challenges and INCLLEN's contributions, past and future, to this central issue in health research today.

Ranjit Roy Chaudhury  
Mary Ann Lansang



## The HIV/AIDS Quality of Care Initiative (HAQOCI)

R A Kambarami and R Masanganise

*Clinical Epidemiology Resource and Training Centre. Faculty of Medicine. University of Zimbabwe.*

### Introduction

Zimbabwe is one of the countries with the highest HIV prevalence rates globally. The response to this epidemic has generally been inadequate. HAQOCI is an initiative aimed at strengthening the response to the HIV/AIDS epidemic in Zimbabwe and assisting with development of infrastructure for delivery of antiretroviral drugs. We describe below a 5-year initiative for HIV/AIDS care improvement implemented by HAQOCI in collaboration with the Ministry of Health and Child Welfare and the WHO country office. The implementers of the HAQOCI are members of the Clinical Epidemiology Resource and Training Centre- Faculty of Medicine – University of Zimbabwe with support from Centers for Disease Control and Prevention (CDC)– Global AIDS Program (GAP).

### Interventions

The process of identifying interventions involved: (1) conducting national stakeholder meetings to build consensus on the HIV/AIDS care needs in Zimbabwe; (2) finding ways of involving strategic partners in the plans for HAQOCI. Furthermore, a national baseline survey on the HIV/AIDS care situation in Zimbabwe was conducted after developing the relevant tools. The identified interventions are as follows:

- Development of HIV/AIDS care Standard Treatment Guidelines for Zimbabwe
- Development of patient information on HIV care
- Development of national training materials and training of healthcare providers on opportunistic infection prevention and management, discharge planning for chronically ill patients, antiretroviral use, palliative care, counseling and nutrition in HIV
- Establishment of opportunistic infections (OI) pilot clinics for the introduction of antiretrovirals in the public sector, scaling up and rolling out this activity.



*Epidemiology students during a residential workshop*



*OI Clinic at Mpilo Hospital*

- Capacity building for AIDS research through a Masters training program in clinical epidemiology by distance education
- Monitoring and evaluation of interventions

By year 3 of the project, various measurable outcomes aimed at HIV/AIDS care improvement have emerged, including the results of the national baseline survey on the HIV/AIDS care situation in Zimbabwe, which are now available. Highlights have been:

- Standard treatment guidelines on HIV/AIDS have been developed and were ratified by the Minister of Health.
- HIV/AIDS Care information packages for PLWHA were developed, translated into vernacular languages and are being distributed to health care facilities.
- National training on opportunistic infections management, discharge planning, antiretroviral drug use, palliative care and counseling for all provinces is ongoing.
- Two OI pilot clinics were established for the introduction of the antiretroviral therapy and operations research. The Ministry of Health is now assisting with expansion of OI clinics nationally with technical assistance from HAQOCI. Of prime importance for the Initiative is advocacy for local production of combination generic antiretroviral drugs. We are happy to report that Zimbabwe is now producing antiretroviral drugs. Infrastructure for the implementation of the WHO 3 by 5 Initiative promises to be solid.
- Forty-one candidates are currently on the clinical epidemiology masters program. This will strengthen capacity for HIV/AIDS research.

**Conclusion:** Through this Initiative we show that with funding support and strategic partners, a coalition of university-based clinical researchers are capable of impacting on health care systems and improving the national response to the HIV/AIDS epidemic.

*Other Selected Abstracts from INCLN Global Meeting XX,  
February 11-14, 2004, Agra, India*

## Health needs, demand for health services and expenditure among the poor

Hakimi M, Dasuki D and Setiawan A  
Gadjah Mada University, Yogyakarta, Indonesia

**Objective:** The Social Safety Net in the field of health launched by the Indonesian Government in August 1998, in anticipation of an economic crisis will finish by the end of October 2003. The objective of this study was to provide inputs to the Community Medical Services Insurance as an exit strategy to solve the problems especially those related to access to health care by the poor.

**Design:** Health interview survey

**Setting:** Purworejo District, Central Java, Indonesia

**Participants:** A total of 311 poor households were randomly chosen from a sample of 12,721 selected households using a two-stage cluster sampling method with probability proportional to estimated size from a total of 152,146 households within the district.

**Interventions:** None

**Main Outcome Measures:** Health status (self assessment, total number of illness episodes, restricted activity days, severity scale), use of health services (all types of uses) and reported health expenditure were used. Reference was made to the

previous four weeks.

**Results:** The assessment of health status across social groups showed the weakest social groups as the most vulnerable. A bad health status was more frequent among people with lower education (no schooling 33.8%), under five (39.8%) and old age (34.5%). There was a strong concentration of needs, uses and expenditures. The last five percentile of the population accounted for 22.6% of total illness episodes and was responsible for 21.6% of the health services used and 77.2% of expenditure. Looking at the concentrations according to the severity index, the situation appeared even more striking: 0.4% of the total population, namely the hospitalized, accounted for 57.4% of total health expenditure with only 1.7% of total illness episodes.

**Conclusions:** This study showed that there was a high concentration of utilization of health services and health expenditure for severe illnesses, indicating the need for programs to promote the utilization of health services and health expenditure toward preventive health care.

## Client perspectives regarding utilization of Vitamin-A and iron folic acid supplementation in India

Arora N.K, Rema Devi, Thomas Mathew, Moumita Biswas and IndiaCLEN Program Evaluation Network  
Clinical Epidemiology Unit, AIIMS, New Delhi, India

**Objective:** Vitamin-A and iron folic acid (IFA) supplements are currently distributed as part of the Reproductive and Child Health (RCH) Program. Despite three decades of operations, the program coverage remained sub-optimal and night blindness and anemia persisted in the community. A process evaluation was carried out to identify the determinants of client behavior.

**Design:** Cross-sectional community-based study. Qualitative methods based on rapid assessment procedures (RAP) were used.

**Setting:** Fifteen centers spread across 15 states of the country were selected on the basis of the major socio-cultural regions of the country and reported coverage under the program.

**Participants:** A total of 1,530 in-depth interviews were conducted with policy makers, program planners, providers, implementers, facilitators and clients. Additionally, 60 FGDs with implementers and clients were also conducted.

**Interventions:** None

**Main Outcome Measures:** None

**Results:** Vitamin-A supplement was generally acceptable (4+) to the clients although a few (<1+) mothers objected to the use of the same spoon for giving the syrup to all children. But

almost half (2+) of the clients were unhappy with the quality of the iron folic acid tablets and thought that there was room for improvement. Fear of side effects from the supplements, socio-cultural beliefs, negative past experiences, poor credibility of the public health system, negative input by influencers and inappropriate location of health facilities also influenced the acceptability of the program. Loss of wages while attending health center activities, payments being asked for in certain government facilities, inconvenient clinic times and expressions like "Why should time be wasted? We could finish our household work in that time" highlight issues of affordability. During clinic visits, the supplements were not available and sometimes the behavior of health staff was unacceptable or indifferent. Inadequate social mobilization activities by the health sector led to a lack of awareness among clients. This was the most important reason for nonutilization of services by the community.

**Conclusions:** The reach of supplementation programs can be increased by an intense social mobilization campaign coupled with measures to incorporate client conveniences in the strategies for program delivery.

## Knowledge translation to policy and practice: INCLIN's Knowledge 'Plus' Program (KPP)



**M**ajor obstacles towards better health still exist between research findings and concrete action to solve global health problems. These problems continue to exist due to inequitable resource allocation of research funds, inability of policymakers and the general public to efficiently utilize research-derived knowledge to make informed decisions, the “information gap” between developed and developing countries, and the unmet need to locally adopt research outputs. Knowledge management is a powerful tool that can facilitate the application of knowledge to directly impact on the health of populations.

The Knowledge 'Plus' Program of the International Clinical Epidemiology Network is one such program that promotes evidence-based decision making for better health by managing the knowledge base on health interventions using measures of safety, efficacy, effectiveness, efficiency and—equally important—equity and local appropriateness. The 'Plus' component of KPP consists of improved tools for assessing *local appropriateness* and *equity*, including the use of “tacit knowledge”.

### Developing Knowledge 'Plus' Packages

KPP aims to develop and implement research-driven health practice guidelines called “Knowledge *Plus*” Packages. The main steps towards the production and use of these KP packages are:

- Identification of priority health problems for a specific country and/or region;
- Identification of stakeholders or clients
- Collection of relevant, available literature and information on interventions for these priority problems;
- Appraisal of information on such health interventions against benchmarks for efficacy, effectiveness, efficiency, local appropriateness and equity;

- Consensus-building among stakeholders on health practice guidelines based on informed appraisal;
- Development, dissemination and implementation of KP packages for priority problems; and
- Monitoring and evaluation.

KP packages are now under development for the country settings of Colombia, India and the Philippines for acute respiratory infections in children under 5 years of age, diagnosis of pediatric TB and management of multidrug-resistant TB, and management of hypercholesterolemia. The criteria for selecting these topics were as follows: high probability of successful implementation of health practice guidelines in terms of program feasibility and stakeholder involvement; differences in policy and practice among countries in terms of equity and applicability; significant equity issues; within the interest and expertise of INCLIN members, and sufficient evidence from research literature, complemented by “tacit knowledge”.

### Expected Impact

The KPP, through its focus on local appropriateness and equity, is expected to achieve a higher specificity and level of integration of “best appropriate practice” for improved health care in developing countries. Its focus on priority health problems of participating countries and regions and the involvement of key stakeholders are expected to achieve optimal knowledge translation into policy and action. “Knowledge managers” are also expected to emerge in the regions and countries, ensuring sustainability and effective knowledge translation.

*Visanu Thamlikitkul*  
Coordinator, KPP

## INCLIN-SEA links evidence and quality

**T**ranslation of evidence to high-quality care encounters unique difficulties in the healthcare systems of developing countries. Acculturation to evidence-based medicine, constraints in health care resources and information systems as well as institutional and government bureaucracies are sufficiently different from those of the West to merit asking whether evidence-based policy instruments can improve the quality of health care in Asia.

Thus INCLIN-SEA conceptualized in 2001 the *Evidence for Quality in Asia and Australia* (EQUAL), a collaborative health systems research project across its member countries. The overall goal is to determine the ways by which evidence is used to develop healthcare guidelines and policies and whether these evidence-based guidelines and policies do improve the processes and outcomes of care.

Phase 1 of EQUAL was a survey of existing evidence-based tools and assessment of the methodological quality of TB Clinical Practice Guidelines (CPGs) in Australia, Malaysia, Philippines, Vietnam, Indonesia, and Thailand. Phase 2 aims to describe how these evidence-based guidelines and policies are being disseminated, implemented

and monitored. It also aims to look at the effectiveness of these evidence-based tools in improving the quality of care and management of tuberculosis.

The project focused on tuberculosis because it ranked among the leading causes of morbidity and mortality among the member countries. The TB CPGs in the six participating countries were identified and assessed for methodological quality. Content analysis showed that the guidelines appropriately endorsed the DOTS strategy in the management of TB, especially in the high-burden countries of Indonesia, Philippines, Vietnam and Thailand. In general, these guidelines provide clear directions on the clinical management of tuberculosis.

Effectiveness of dissemination strategies and methods of implementation are currently being evaluated by the Clinical Research Centre in Kuala Lumpur as part of Phase 2. Barriers and facilitators to dissemination and implementation are also being explored. .

*Marissa Alejandria*  
EQUAL Coordinator, Philippines

## Latin-American Ongoing Clinical Trials Register (LATINREC)

**W**ell-conducted systematic reviews and randomized controlled trials (RCT) often provide the most reliable and highest level of evidence about the effects of healthcare interventions. The author of a systematic review must try to find all relevant evidence in an attempt to minimize publication bias. It is well known that negative results are less likely to be published, thus leading to distortion of the body of evidence available for clinical decision-making. Additionally, some trial results are not easily retrieved because they have never been published or have been published in non-indexed journals (1-3).

However, several major barriers have been described for developing a comprehensive register of clinical trials: industry resistance, insufficient funding to make it sustainable, difficulties enforcing registration, and lack of awareness of the problems of not registering trials (4).

In a recent editorial, the International Committee of Medical Journal Editors (ICMJE) and the *British Medical Journal* have promoted a solution to selective reporting of clinical studies. In this editorial, published simultaneously by all member journals, the ICMJE announced that all members will adopt a trial-registration policy in which registration in a public trials database will be required as a condition for publication (5, 6). The ICMJE editorial also supports comprehensive trial registers that meet several criteria (5). Additionally, an international agenda to capture all controlled trials in a global register has been promoted by the World Health Organization (7).

Nevertheless registers for trials are at an early stage of development, particularly in developing countries. Few trials from developing countries end up being registered in existing databases, partly because of poor awareness of the problem, language barriers and the cost of registration in some databases.

In response, some members of the Latin American Clinical Epidemiology Network (LatinCLEN) were awarded a grant by INCLEN in 2003 to design and implement a database for the ongoing register of clinical trials in Iberoamerica. In March 2004 several Colombian contributors to the Iberoamerican Cochrane Network of the Cochrane Collaboration set up the Latin-American Ongoing Clinical Trials Register (LATINREC) to share basic information about ongoing trials. This register meets several of the criteria recommended by the *British Medical Journal*, the ICMJE and the *Ad Hoc* Group for Prospective Registration of Controlled Trials (5,6,8), and is expected to be functional from November 2004 (visit [www.latinrec.org](http://www.latinrec.org)). Registration will be free of charge and its content will be freely available to the public. The register will also facilitate access to other tools and methodological information for Latin-American trialists.

The pharmaceutical industry, universities, research centers and local databases from Latin America are invited to register their research projects. Through Medline, the Cochrane Library and Lilacs databases, we will actively search for trialists possibly involved in RCTs and try to contact them.

A free “Metaregister” combining several registers of ongoing RCTs should also be encouraged to guarantee a comprehensive database and to ensure ethical transparency in research.

### References

1. Phillips CV. Publication bias in situ. *BMC Med Res Methodol* 2004 Aug 5;4(1):20.
2. Wager E. The need for trial identifiers. *Curr Med Res Opin* 2004; 20(2):203-6
3. McAuley L, Pham B, Tugwell P, Moher D. Does the inclusion of grey literature influence estimates of intervention effectiveness reported in meta-analyses? *Lancet* 2000; 356:1228-31.
4. Dickersin K, Rennie D. Registering Clinical Trials. *JAMA* 2003; 290:516-523. De Angelis C, Drazen JM, Frizelle FA, Haug C, Hoey J, Horton R, Kotzin S, Laine C, Marusic A, Overbeke AJ, Schroeder TV, Sox HC, Van Der Weyden MB. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *CMAJ* 2004 Sep 14; 171(6): 606-7. Abbasi K. Compulsory registration of clinical trials. *BMJ* 2004; 329:637-638.
5. De Angelis C, Drazen JM, Frizelle FA, Haug C, Hoey J, Horton R, Kotzin S, Laine C, Marusic A, Overbeke AJ, Schroeder TV, Sox HC, Van Der Weyden MB. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *CMAJ* 2004 Sep 14; 171(6): 606-7.
6. Abbasi K. Compulsory registration of clinical trials. *BMJ* 2004; 329:637-638.
7. Dickersin K. Report to the World Health Organization (WHO) on a Plan for International Registration of Controlled Trials. Available at: [www.who.int/rpc/meetings/en/WHO2.pdf](http://www.who.int/rpc/meetings/en/WHO2.pdf) Accessed September 2004.
8. Ad Hoc Group for Prospective Registration of Controlled Trials. Data items for prospective registration of controlled trials Available at: [http://www.controlled-trials.com/mrct/data\\_items.asp](http://www.controlled-trials.com/mrct/data_items.asp) Accessed September 2004.

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## Clinical epidemiology and health systems research: Bridging the past and the future

**D**uring the World Health Assembly in 1987, being in charge of the Health Systems Research Programme at WHO/HQ, I had a meeting with Scott Halstead, at that time Associate Director of Health Sciences at the Rockefeller Foundation, major sponsor of INCLEN. During this meeting he expressed the Foundation's interest in broadening the scope of training and research in INCLEN to encompass health systems research, to strengthen the links between clinical epidemiology units (CEUs) and ministries of health, and to support more effective utilization of research findings for decision-making. As a result of our discussions I was invited, together with another WHO colleague, to visit three North American Clinical Epidemiology Research and Training Centers (CERTCs) in order to identify specific steps to address these concerns. The visits took place the same year and our recommendations for closer collaboration between WHO and INCLEN included efforts to:

- encourage CEUs to undertake epidemiological and **health systems research**,
- increase the probability of effective utilization of research findings by promoting **linkages between the CEUs and the ministries of health**,
- broaden the scope of training of INCLEN fellows, by including the application of **epidemiological methods to research in health systems and behavioral sciences and health economics** as essential disciplines in **health systems research**.

As a contribution to "spreading the gospel", the Rockefeller Foundation decided to give a start premium to *Bridge*, an international newsletter, which had an ambitious but relevant subtitle "Linking the producers and users of health systems research and clinical epidemiology". A total of 18 bi-annual issues of *Bridge* were published between 1989 and 1998, in English, Spanish and Arabic and each issue included an "Invited commentary" by an international expert in the field of health systems research or clinical epidemiology.

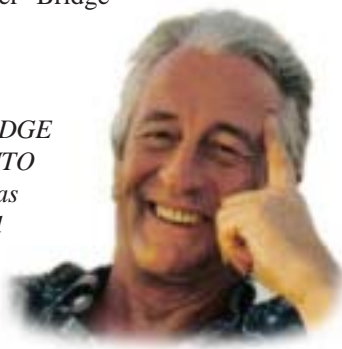
An analysis of these commentaries in the following pages illustrates and gives evidence to INCLEN's efforts to implement the above recommendations over the last two decades by:

- profiling and constructing clinical epidemiology as a bridging discipline between health care (medicine) and health systems (public health);
- strengthening its capacities in (health systems research-related) disciplines, like biostatistics, health social sciences and health economics; and
- narrowing the "know-do" gap in looking for a more proactive dialogue with all stakeholders in the health research system.

Now facing the Millennium Development Goals, INCLEN looks forward to facilitating the translation of the spirit of the Puebla Declaration in support of health research for development, of which it was one of the 10 signing agencies in 1989, into the upcoming Mexico Action Agenda in 2004, which would be another "Bridge" between the past and the future.

### Yvo Nuyens

*Yvo Nuyens was the co-founder and editor-in-chief of BRIDGE (1989-1995) and the editor-in-chief of RESEARCH INTO ACTION, the newsletter of COHRED (1995-2000). He was also in charge of the Health Systems Research and Development Programme at WHO/HQ (1984-1993). Currently he works as a private consultant with a number of international research organizations and national research institutions.*



**T**he case for health systems research has eloquently and with good reason over the century. Despite repeated clongs on the variety of initiatives, the signal-to-noise ratio for health systems research has remained appallingly feeble. Further analyses about why HSR has failed to register undoubtedly be insightful and should not be. However, we simply do not have the luxury of such at this juncture of global health.

With just over 10 years remaining to achieve the MD ourselves in the health field with an impressive arm of interventions to improve the life chances of millions of children. We also find ourselves with unprecedented support with the advent of billion dollar funds. And in we are rediscovering once again that health systems



### Background

An analysis of the Invited Commentaries in the 18 issues of *Bridge*, published between 1989 and 1998, resulted in the identification of four major issues/themes/areas which have critical relevance for the present discussion about health systems research (HPSR) and the MDGs :

- overall status of the field and its socio-political environment
- capacities to produce and use HPSR and clinical epidemiology

## Political Environment

### Redesign health systems

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systems-- the

backbone processes that organize the workforce, the financing, the drugs and diagnostics and information critical to all interventions—are the primary constraints to progress.

The diagnosis, although valid, lacks a clear prescription: how do we fortify health systems whose primary foundations are so fragile? How do we mobilize a workforce that is competent and committed to serving the neediest populations in an environment of accentuated brain drain and miserable working conditions? How do we design health systems so that millions are not impoverished through the process of seeking care? How do we expand coverage of interventions that we know are life saving more quickly?

These questions are among the many that will remain unanswered without a very significant global commitment to generating knowledge about how health systems can better serve their

constituents. The Mexico Summit should not miss the opportunity of putting this orphaned area of research squarely on the agenda--the lives of mothers and children are dependent on it!

#### Tim Evans

*Dr Evans is currently Assistant Director-General for Evidence and Information Policy at the World Health Organization, Geneva, Switzerland. He served as the Director of Health Equity at the Rockefeller Foundation from 1997 to 2003.*



### Health systems research: the missing links?



**F**ocus on organization, delivery and the supply side of health systems; has brought significant insights into health systems but challenges still remain. In the same country, with similar infrastructure and resource availability, systems perform remarkably in some states/regions while they remain completely ineffective in others. Our own studies in India have indicated that program managers working for polio eradication in better performing states were able to identify difficulties and barriers in achieving program objectives; on the other hand, in states with continued occurrence of wild virus cases, the program people thought that “everything is fine”. How does one measure quality of governance, motivation and insight?

It is not uncommon that clients would not approach a functioning health facility located next door. Acceptability of public health services and client utilization behavior in resource-poor societies are important determinants of coverage. There are segments of the population who are so engrossed with basic survival issues that seeking health is a low priority; they are most vulnerable and in greatest need of health services. How to understand their side of the story and take services at their door step?

Why systems work - is it the demand by the political bosses to deliver or heightened expectations of the community? Do we have to wait till the public expenditure in health increases?

We need to have faith on both implementers of programs communities. Decentralization can lead to some mistakes but a lot of learn and sustained strengthening of health systems will accrue.

**Narendra Arora**  
*Incoming Executive Director  
INCLIN Trust*



- the “Know-Do” gap : from research to policy and practice
- networking and partnership.

These four major themes have been documented and illustrated by a number of *Bridge* citations, which were then submitted to a series of experts inside and outside INCLIN for their comments. The experts were invited to focus their comments on progress made and outstanding challenges in HPSR, roles and challenges for the related disciplines and their professional organizations in addressing the MDGs.

*Yvo Nuyens*

## Integrating ideas and power

**I**n 1995, while I was the Director of the Centre for Health and the Economy in Mexico, I wrote an editorial for the COHRED Newsletter, under the title “The power of ideas and the ideas of power: challenges to ENHR from health system reform”.<sup>1</sup>

Nearly a decade later, I can only confirm --- this time from my position as a decision-maker rather than a researcher – that many of the basic messages of this editorial are still relevant, and in some cases even more relevant than when they were first written. Some extracts are given below.

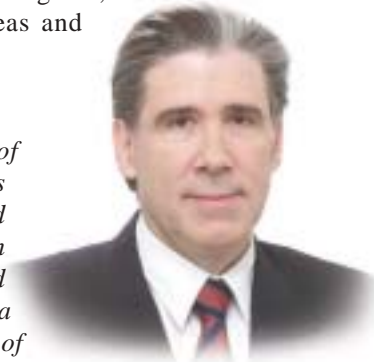
“... While it is clear that decisions are made on the basis of many other forces apart from scientific information, it is also true that good evidence can steer those who have the power to decide towards a better course of action. In other words, the power of ideas can help to shape the ideas of power... The value of sound research to enlightened decision-making is underscored by the wave of health reform that currently is sweeping the world... The process of rethinking and renewing health systems needs to be illuminated by research. There are still so many unknowns about the determinants of health system performance that a research agenda must be an integral part of every reform initiative... a strategy to ensure that priorities are defined in a participatory manner, that projects respond to the most pressing national problems, and that explicit bridges are built between researchers and decision-makers for the optimal use of research...”

“While every reform experience will have features that are specific to its national circumstances, there are always important lessons for other countries to learn. Hence, there is need for concerted actions among countries in order to compare options and evaluate experiences. National initiatives will have a higher likelihood of success if they can all benefit from a global mechanism for shared learning... The proposed mechanism might adopt several forms, but what is important is that it should have a guiding mission as a resource for all countries in the world. This would help to supersede the false dilemma between national and global research...”

“Reform and research should walk together in the quest for better health. When we can achieve convergence, we will have at last integrated ideas and power...”

### **Julio Frenk**

*Dr Frenk is the current Minister of Health in Mexico. Prior to this, he was Executive Director of Evidence and Information for Policy, World Health Organization, Geneva, Switzerland (1998-2000). He also served as a member of the Board of Directors of INCLEN, Inc. (1995-1997).*



<sup>1</sup> *Research into Action*, Issue 2, July-Sept 1995.

## Closing the “know - do” gap

**W**hy is it that in spite of *knowing* what is good for them, people *do* the opposite? Why is it that even if scientific evidence shows that a health intervention (e.g., salt iodization) is beneficial to a population, local governments will not impose it (mandatory sale of iodized salt), or people will not buy it? Why is it that despite the passage of a Philippine law in 1995 mandating the universal use of iodized salt, the implementation at the local government level has been sluggish?

I attribute this to a number of *systems* and *multi-sectoral* factors: (1) Poor empowerment of Local Government Units; (2) relatively higher price of iodized salt over non-iodized salt, and (3) inadequate understanding among lower-income people of the benefits of iodized salt for brain development of their children.

To address these problems, vigorous mass campaigns were launched from late 2001 to 2003 in the Philippines to improve enforcement of the law. These increased iodized salt utilization levels from 25 to 75 percent. Through market inspection, retailers of salt have been forced to sell only iodized salt under penalty of a fine. The enforcement has worked, but there are reports that the old habit dies hard and that retailers continue

to sell non-iodized salt surreptitiously, trying to take advantage of the 20 percent lower price that the poor would go for. The eventual solution is ever stricter enforcement perhaps, and the punishment of wholesale distributors who will continue to exploit the price differential in order to sell their non-iodized salt to consumers.

But despite these challenges, the trend towards iodized salt has been set; and the “know – do” gap in this particular instance is gradually being closed.

### **Manuel Dayrit**

*Dr Dayrit is the current health minister of the Republic of the Philippines. His prior positions include founder and Program Manager of the Field Epidemiology Training Program in the Department of Health and founder of the country's HIV/AIDS program.*



## Linking producers and users of health research

One thing seems clear if we are to achieve a positive result in the three health-related Millennium Development Goals by 2015: these results can only be the product of stronger health systems in the poor countries of the world. In the midst of a rising global burden of disease and failing public health actions, the attainment of such goals remains a challenge. While stronger health systems need to come about by energetic, targeted (and perhaps expensive) multi-faceted approaches, one essential component is that of a stronger link between the producers and users of—badly needed—health policy and systems research. The gap between what is known and what is translated, especially as applied in health systems, needs to be bridged. As with any gap, bridging efforts will need a firm commitment from both sides, so that evidence truly informs decision-making at the health system level. As has been mentioned repeatedly in the past decade, there are some solutions to health systems activities that are available but these have not been applied or scaled-up. INCLIN

and clinical epidemiology have the mandate and the know-how to help in this critical task. Clinical epidemiology can significantly help promote and maintain healthier health systems, not only in the production but also in the synthesis and translation of ethical, culturally appropriate, and relevant knowledge to achieve the MDGs.

### Rodolfo Dennis

*Dr Dennis is a senior program consultant of INCLIN. He is a professor of Medicine and Clinical Epidemiology at the Pontificia Universidad Javeriana and Head, Departments of Medicine and Research, Fundación Cardio-Infantil, Bogotá, Colombia.*



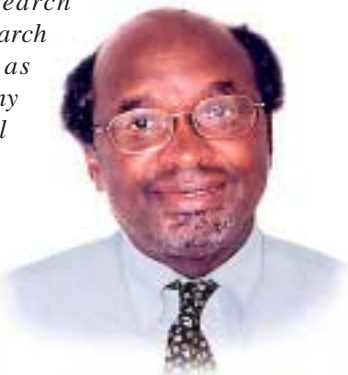
## Networks and Partnerships

### The AfHRF experience

Enterprises use networking as a strategy for efficiency and productivity improvement. Similarly networks add value to health research. Therefore creation of networking and partnerships at national, regional and international levels are strategic measures for reducing existing global imbalances in health research. Many health research networks operate in Africa but despite their potential for promoting research development, impact remains modest. Donor dependence by most of these networks distracts them from comprehensively dealing with cross-cutting issues constraining research growth. To enhance their effectiveness, analyses are needed to identify synergies that are beneficial. The African Health Research Forum (AfHRF) is a recent mechanism for promoting partnership building and for “value-added” to networks. In addition the Forum will serve as a platform for research stakeholders to generate a ‘voice’ of countries to the international health research systems. The messages would help to set an agenda for Africa’s contribution in global health research and health systems improvement.

### Mutuma Mugambi

*Dr Mugambi is a professor of health sciences and is the Vice Chancellor of the Kenya Methodist University. His current activities include research management and health research development, serving as consultant or adviser to many international and regional bodies. Prof. Mugambi was instrumental in the establishment of the African Health Research Forum (AfHRF), which is envisioned to strengthen the African voice in shaping and implementing the global research agenda.*

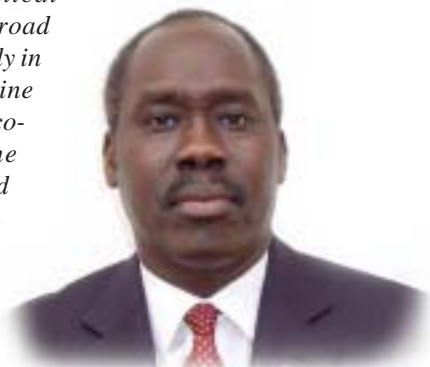


### Opening new doors

INCLIN has made important strides in generating new knowledge. The network’s recent transformation emphasizes regionalization and partnerships, with steps being taken by each regional network to establish and strengthen collaborations in-country, regionally, and globally. Research, through a priority-setting exercise that includes in-country and regional health planners and implementers, must be linked with a plan to develop policy and implementation of research findings through a transparent and participatory process. Forums for such collaboration must be created, often through new partnerships and networks. Equity and local appropriateness are the new focus in INCLIN’s strategic plan, which have truly refocused INCLIN’s mission to meeting the challenges of HPSR. This thrust has created special challenges in the different regions of the network, but if INCLIN and other research organizations are to remain relevant in the context of the Millennium Development Goals, then continued innovation in this area is necessary.

### James Hakim

*Dr James Hakim is an associate professor and the chair of the Department of Medicine at the University of Zimbabwe. He is an internist and clinical epidemiologist with broad research interests mainly in cardiovascular medicine and HIV/AIDS. He is co-coordinator of the INCLIN Leadership and Management Program (LAMP) and a member of the INCLIN Virtual Campus Steering Committee.*



## Capacity Development

### Redouble HSR efforts

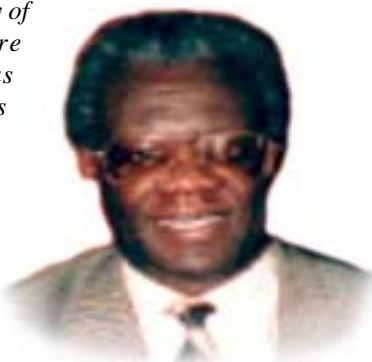
Evidence is continuing to accumulate that the attainment of the Millennium Development Goals and the successful implementation of major global health initiatives for health are severely constrained by severe inadequacies of health systems. In addition there is both inadequate production and utilization of research results for action or policy decision-making. We need to move quickly to address the above deficiencies using the relevant disciplines including social sciences, clinical epidemiology and public health specialties. Little progress has been made globally in the last decade. A major bottleneck is insufficient human resources that are well qualified and committed to undertake research in this field. Even when well trained and committed personnel are available in institutions and networks like INCLEN, they do not get adequate support and resources to motivate them and enable them do what is needed.

Only very recently are major efforts being made to strongly advocate and stimulate action for addressing issues related to health systems research. At least two major recent developments in this regard deserve recognition and attention by all stake holders who have an influence in the health sector: The Joint Learning Initiative started by Rockefeller Foundation, having extensively examined inadequacies of human resources for health, has issued a detailed report with a series of recommendations that need to be translated into concrete action for results; The WHO Task Force for Health Systems Research has identified a number of priority research topics for which international collaborative research could help generate the knowledge necessary to improve performance of health systems.

The time is now for all individuals, institutions and networks for health to redouble their efforts and work to harness and act on the recommendations made by the above two initiatives. Equally important is that all stakeholders who have an influence in resource allocation for the health sector should review those recommendations with the intent to stimulate action that will lead to generation and use of quality research that will have impact on the health systems and health policy.

#### Nelson Sewankambo

*Professor Sewankambo is currently Dean of the Faculty of Medicine at the Makerere University, Uganda. He has published numerous studies on HIV/AIDS epidemiology, prevention and treatment and contributed significantly to successful HIV/AIDS control programs in Uganda. He served as a member of the INCLEN, Inc. Board of Trustees (1998-2000) and INCLEN Board of Trustees (2001-2003).*



### Improve communication locally

Will recent progress in understanding issues in “strengthening capacity” for health research help accelerate the achievement of the MDGs? The major challenge to achieving the MDGs occurs in countries with the weakest health system capacity. Is it feasible to strengthen health *research* capacity in such countries so as to impact on progress towards MDGs?

“*Capacity strengthening*” involves strengthening three components of health research: the producers and potential users of research, and supportive institutional mechanisms. In brief, we need to create and sustain a critical mass of researchers capable of analyzing priority issues, producing good quality evidence on how to best address critical constraints, and able to support the use of such evidence in changing health policies and health care practices. Simultaneously, we need to stimulate interest and create the ability among potential users such as policy makers, healthcare providers, and community decision makers to recognize priorities, and seek and use the best available evidence to address them. And mechanisms are needed to provide incentives, fund priorities, and sustain two-way communication and support between producers and potential users of research.

However, the countries at highest risk of failing to meet the MDGs are faced with political instability, and social and physical insecurity. Continued ‘brain drain’ of trained personnel results in the inability to deliver the most basic health care. In the immediate future, the best potential for reaching the MDGs in such countries might be affordable, easily delivered technological interventions (such as vaccines and drugs) developed in ‘higher capacity’ countries. If so, research capacity strengthening towards achieving MDGs would need to establish and sustain two-way communication so that experienced international researchers work with policy makers, healthcare providers and consumers in poor countries to analyze priority problems, develop appropriate interventions, and support the application of such interventions within the local context.

#### Indra Pathmanathan

*Dr Pathmanathan, a Malaysian public health physician, pioneered in health systems research and capacity strengthening in several developing countries during the 1980s. As a senior public health specialist at the World Bank in the 1990s, she gained insights into health policy making and implementation in developing countries and international organizations. She now works as freelance consultant for various international organizations including the WHO.*



# The INCLLEN Trust Mission

*We are a unique, global network of clinical epidemiologists, biostatisticians, social scientists and other health care professionals affiliated with leading academic medical institutions.*

*We are dedicated to improving the health of disadvantaged populations, particularly in low- and middle-income countries, by promoting equitable health care based on the best evidence of effectiveness and the efficient use of resources.*

*We achieve this by conducting collaborative, interdisciplinary research on high-priority health problems, and by training future generations of leaders in health care research.*

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## Editor's Note

The INCLLEN Executive Office assumes full responsibility for editing and publishing the INCLLEN Newsletter bi-annually.

The newsletter serves as a forum for exchanging information and current research among INCLLEN faculty and associates and also introduces first-time readers to INCLLEN activities.

This newsletter continues to enhance its focus on the research activities and training of the INCLLEN faculty.

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# Dr Narendra Arora named new INCLLEN Trust Executive Director



INCLLEN is pleased to announce the selection of Dr Narendra Arora as its new Executive Director effective December 1, 2004. Dr Arora, professor of pediatrics at the All India Institute of Medical Sciences (AIIMS), Delhi, has led many health and research programs throughout his career, and has successfully contributed to the advancement of global and national agendas for health policy and systems research. He serves as member coordinator of India's National Certification Committee for Polio Eradication (NCCPE). He is the team leader of the IndiaCLEN Program Evaluation Network (IPEN), a network of more than 80 Indian centers and six Clinical Epidemiology Units that have been involved in conducting evaluations of public health programs in India. Most recently, Dr Arora and IPEN completed a nationwide assessment of injection practices in India. His research in the area of pediatric gastroenterology and nutrition has led to the standardization of improved methods for the management of infants with intractable diarrhea and characterization of infection due to hepatitis E virus in childhood. He is also a member of the Indian working group for Review of National Nutrition Policy and National Plan of Action on Nutrition.

As Executive Director, Dr Arora plans to implement the new INCLLEN Strategic Plan for 2003-2007 with renewed vigor and to further strengthen the regional Clinical Epidemiology Networks.. "We have to perform and demonstrate our capability to influence global, regional and national health policies and programs through evidence generated by us," he said. When discussing the urgency of finding answers on a global scale for the world's most pressing health issues, Dr Arora stated, "INCLLEN, with more than 700 trained professionals from 70 academic medical institutions located in 7 regions, is potentially one of the most powerful institutions present to respond to global health challenges." To do this, he

## INCLLEN Trust Clinical Epidemiology Units (CEUs) and Clinical Epidemiology Research and Training Centers (CERTCs)

said, "It is critical that the capacities built over the last two decades are brought together in a manner that leverages these capabilities, and INCLLEN as an organization moves to the vanguard of efforts to provide simple, feasible, and efficient answers to seemingly complex public health issues."

From a personal perspective, Dr Arora reflected that "INCLLEN has contributed significantly in shaping my life as a research investigator, teacher and a clinician over the past 10 years. I am ready to take up the challenge that the position of Executive Director offers and am confident that I should be able to make a difference."

