

INCLLEN news

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Social inequalities in health: challenges and opportunities for research

by: James Volmink, MBChB, DPhil
University of Cape Town, South Africa

An abridged transcription of a plenary talk presented at the INCLLEN Global Meeting XIX, Kunming, China, February 21, 2003

This talk covers an overview of social inequalities in health, differences between inequality and inequity, conceptual challenges in the field of health and equity and opportunities for equity research.

An example of social inequality in health is the difference in age of death across social classes in Liverpool in 1840. The average death of the gentry and the professional

class was 35 years; for tradesmen and their family—22 years; and for laborers, mechanics and servants—15 years. Differences can also be observed between health status of poor and non-poor populations or between rich and poor countries. What accounts for these differences? Some have blamed biological factors claiming that social positions are determined by inherited characteristics, for example:

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Equity and clinical epidemiology

by: Peter Tugwell, MD, MSc, FRPC

Centre for Global Health, Institute of Population Health, University of Ottawa, Canada

A summary of a plenary talk presented at the INCLLEN Global Meeting XIX, Kunming, China, February 21, 2003

In a plenary session on Evidence-based Medicine and Equity in Health, Dr. Peter Tugwell described the importance of "Action-Oriented" involving a shift from static emphasis upon health inequity analysis towards dynamic identification and

evaluation of measures that can effectively bring about greater equity (Gwatkin, 2001). An acronym that serves to illuminate the multidimensionality of the term disadvantage in terms of both access to care and health status is PROGRESS, developed by Hilary Brown and Tim Evans at The Rockefeller Foundation. This acronym is not meant to be an exhaustive list; rather it captures the broad nature of some of the underlying determinants of health equity beyond income. PROGRESS stands for: Place of residence, Race/ethnicity/culture, Occupation, Gender, Religion, Education, Socioeconomic status and Social capital.



Doctors Qi Guomin, Peter Tugwell, and James Volmink at the INCLLEN Global Meeting XIX in Kunming, China

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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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Fletchers' new clinical epidemiology book targets the public

Drs. Robert and Suzanne Fletcher were awarded Scholarships in Residence at the Rockefeller Foundation's Study and Conference Center in Bellagio (Lake Como), Italy to write a book in clinical epidemiology for the general public. The book is envisioned to help people outside the medical field understand how medical information is developed and communicated. Specifically, the purpose of the book is to help people become better health care consumers and to help patients prepare themselves for useful collaborations with their physicians when making health care decisions.

The Fletchers began the work in April 2003 as Scholars in Residence at the Rockefeller Foundation's Study and Conference Center in Bellagio. Two members of the INCLen community, Mary Ann Lansang (INCLen Trust Executive Director) and Kerr White (the one who initiated INCLen while an officer of the Rockefeller Foundation), wrote support letters for the Fletchers for this scholarship. Aside from having a valuable block of time that allowed them to begin the project, the Fletchers appreciated the feedback from their fellow scholars, most of whom are not physicians. Such feedback helped them understand their target audience better. As for their stay in Italy in general, the Fletchers had this to say, "We got a good start on the book during our time in Italy but still have some hard work ahead of us."

Why is this project important? People can now find vast amounts of health information – both gems and junk – on the internet. In fact, in

the United States, people use the web more for finding health information than for looking up sports scores or making purchases. Also, patients are increasingly encouraged to participate with their doctors in healthcare decisions but they may be inadequately prepared for this new role. The Fletchers hope that the book will help people distinguish good from bad health information, ask the right questions, and be more confident and well informed during discussions about their own health care.



The Fletchers in Bellagio

During the course of writing the book, the Fletchers learned that the concepts of clinical epidemiology are not difficult for people outside of medicine to understand. The greater challenge is to capture and retain readers' interest. There are, after all, many other ways of dealing with health information, such as wishful or magical thinking and belief in the views of "experts" who are especially eloquent, forceful, or confident in their advice.

For the Fletchers, this work is a logical extension of their lifelong interest in teaching clinical epidemiology to health professionals. Now it is the patients' turn.

Progress Report

INCLen'S Knowledge 'Plus' Program Teams press on

In 2002, INCLen initiated the Knowledge "Plus" Program, also known as the KPP, with seed funding from the Rockefeller Foundation. The KPP aims to develop Knowledge 'Plus' Packages, which are health practice guidelines that are based on high-quality and relevant research studies. In addition, the Knowledge Plus Packages attempt to address equity issues by considering knowledge that is locally appropriate and important to the most needy, hence the 'Plus' component of the program.

In October 2002, four teams were formed to implement the KPP plans. Team A, headed by Dr. Juan Gabriel Ruiz (Colombia), focuses on identifying priority health care issues for specific health problems, the appropriate clients and other stakeholders, criteria to standardize and assure quality of methods, and systematic search and review of relevant literature. Team B, headed by Dr Antonio Dans (Philippines), focuses on the development of tools and filters to appraise the validity, applicability and equity of studies to be included in the knowledge base. Team D, headed by Dr. L. Jeyaseelan (India), is the ICT team, which will design a web-based information system for the research

studies to be included in the knowledge database. This team will also develop or adopt the most appropriate search engine for KPP's systematic reviews. Team C, headed by Dr. Visanu Thamlikitkul (Thailand), is the coordinating team. Team members cut across CLENs and member countries of INCLen, hence much of the KPP work is accomplished through regular electronic dialogues. At the INCLen Global Meeting XIX February 2003 in Kunming, China, the team leaders and some team members met face-to-face for the first time to assess accomplishments and chart future activities within and across the teams.

Team A has assembled sub-teams and recruited task force leaders for each of the chosen health topics for the pilot phase. The task force leaders are Juan Manuel Lozano (Colombia) for acute respiratory tract infections (ARI) in children under 5 years; C.S. Ghosh (India) for management of tuberculosis; James Hakim (Zimbabwe) for anti-retroviral therapy for HIV infections; and Alvaro Ruiz (Colombia) for management of hyper-cholesterolemia. These topics were selected based on the following criteria: 1) burden of disease; 2) potential for making a difference in policy and practice
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KPP Teams at INCLen GM XIX in Kunming, China

Social inequities . . . (from page 1)

“a process of social sifting...had left the working classes inferior on average to their 'social betters' in respect of health, physique and mentality, while the lowest strata of manual workers contained a higher percentage of men and women from 'tainted stock.'”

-Eugenic movement in early 20th century

Others suggest behavioral factors. Ignorance or irresponsible behavior is at the root of poverty-related diseases (e.g., smoking, poor diet, inappropriate use of health services). One health official in Newcastle-upon-Tyne had this to say about the death rate among young children in his town:

*“The terribly heavy death rate among young children in our town is, of course, due to a certain extent to the relative unhealthiness of our surroundings, but that is by no means the chief cause. The factor that is of primary importance is **maternal mismanagement...**”*

-Assistant Medical Officer, Newcastle upon Tyne, 1910

There are undoubtedly differences in health-related behaviors. Smoking is more common among the less educated men in Chennai, India. The use of oral rehydration therapy and full immunization rates differ between poor and rich populations in developing countries. The question is: why do these differences exist? Why do the poor not take their tuberculosis (TB) medication? P. Farmer (1997)¹ has this to say:

“In most settings where TB is prevalent, the degree to which patients are able to comply is significantly limited by forces quite beyond their control...those least likely to comply are those least able to comply...”

This brings us on to the third explanation for social differences in health, which relates to environmental factors. Living conditions, including poor nutrition, overcrowding, lack of sanitation and inadequate health care, linked to social position and education, cause ill-health and early death. As the gap between rich and poor increases, so do health inequalities.

At this point, it is important to differentiate inequality from inequity. Inequality in health refers simply to differences across individuals in the population. Inequity specifically relates to differences in health that are potentially remediable. The International Society for Equity in Health defines inequity as the “*systematic and potentially remediable differences in one or more aspects of health across socially, economically, demographically or geographically defined population groups or subgroups.*”

The underlying idea is that some inequalities are unfair or unjust. Thus the WHO/Euro (1990)² considers inequity as differences in health that are “unfair and unjust”. Invariably this involves judgment about whether differences are due to inherent biological variation, informed individual choice and whether it is potentially remediable.

What has been the international response to the problem of inequity? Various initiatives have been initiated over the past 25 years:

- Alma Ata Conference on Primary Health Care, 1978
- WHO Euro: Social Equity and Inequalities in Health Programmes, 1983
- World Bank: World Development Report, 1993
- WHO: World Health Report, 1995
- Rockefeller Foundation: Global Health Equity Initiative, 1995-2000
- United Nations: Millennium Development Goals, 2000
- Development agencies

These initiatives remind us that dealing with inequity is a social responsibility.

In conducting research on health and inequity, however, certain conceptual challenges will be encountered. First, what is the most appropriate measure of “exposure?” The following have been suggested or used: occupation or occupational class, educational attainment, asset-based measures (e.g., income, ownership of cars or housing), area-based indices of deprivation (e.g., Carstairs Index and the Townsend Score). The Carstairs Index is based on percentages of unemployed males, overcrowded households, households without cars, and persons in social classes IV and V living in a defined area at the last census. The Townsend Score is based on percentages with no car, in overcrowded dwellings, living in non-owner occupied and unemployed at the last census.

Does the choice of “exposure” matter? Some observed inequalities are consistent, regardless of the measure used, but for others, the magnitude of the differentials depends on what measure is used. There is also the issue of absolute versus relative deprivation (e.g., “dose-response” relationship, average life expectancy in a country depends less on the average income than on the income distribution).

The second conceptual challenge is “What outcome measures should be used?” Process measures like health financing and expenditure, and access to and utilization of services have been suggested. Likewise, health outcomes like self-report and physical examinations can be used. The issue of horizontal versus vertical equity has also been considered. Health workers can choose from these possible outcome measures but does the choice of the outcome matter? For example, health ‘status’ measures like chronic illness show steeper social differentials than health ‘states’ (e.g., symptoms). Measures of health status that combine mortality and morbidity (e.g., DALYs) demonstrate the effects of social factors to a greater extent than survival measures alone.

A third conceptual challenge is misclassification and confounding. Examples of potential misclassification arise from threshold differences among social class groups for recognising or reporting ill health or disability. The effects of material or social deprivation may be confounded by the effects of social position. For example, black/white mortality differentials remain after adjusting for socioeconomic status. Biological “programming” in utero or early infancy (Barker hypothesis) can confound associations between adult exposures and ill health.

Given these situations and challenges, what opportunities do we have as researchers to address the problem of inequity? A COHRED document (March 2, 2002)³ states that research is “...one of the main instruments for promoting equity in health...”

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LatinCLEN completes ICT system, integrates distance learning and LAMP programs

LatinCLEN's ICT system (www.latinclen.org) is now complete. Considered as one of the most important achievements of the network by its Executive Committee, the ICT system is an important aspect of both the Distance Learning Program and the Leadership and Management Program, two ongoing projects of the network. LatinCLEN decided to integrate these two programs. This integration was first presented to the network's members at LatinCLEN VIII (www.ciges.cl/latinclenviii) regional meeting. Held in the cities of Temuco and Pucón, IX Region of Chile on May 28-31, 2003 with the theme "Distance Learning for Leadership and Management in Health", the LatinCLEN VIII was attended by 82 LatinCLEN members and partners. The meeting featured plenary sessions on "Organizational Development" and "Mentoring Approaches for Conducting Strategic Plans", and a workshop on "Building Tutoring Capacity for the Distance Learning Master Program"

LatinCLEN plans to launch its Distance Learning Master Program in Clinical Epidemiology before the end of the year. An Academic Board of the Program was created with Pedro Lorca as Program Director and Pamela Seron as Academic Coordinator. Members are: Juan Manuel Lozano, Javeriana CERTC Director; Sergio Munoz, UFRO-CERTC Director; and Antonio da Cunha, LatinCLEN Executive Committee representative. The site was launched during LatinCLEN VIII and can be visited at <http://docencia.iie.ufro.cl/mec>. For any questions contact mec@ciges.cl

For LAMP, a program on "Mentoring of Teams" is being conducted and concurrently evaluated in the region. The program is targeting teams like CEUs and collaborative research groups. Members of the CERTCs in Temuco, Chile (Universidad de la Frontera) and in Bogota, Colombia (Javeriana University) have been trained to be tutors of groups on "Conducting Strategic

Planning". A revised version of the Strategic Planning Module, with a broader emphasis on "strategic management", is under consideration. Two workshops on strategic planning and management were conducted using specially designed materials. The products of these workshops would constitute a set of materials to be used for developing the strategic plans of new CEUs.

Meanwhile, the LatinCLEN Board of Directors elected the new Executive Committee for the period 2003-2005. Juan Manuel Lozano (Colombia) took over as President; with Antonio da Cunha (Brazil) as Vice-President, and Enrique Rendon (Mexico), Myriam Orsotegui (Colombia) and Sergio Munoz (Chile) as Executive Committee (EC) members. Aside from the Academic Board of the Distance Learning Program, the EC also created the Scientific Committee, composed of the following members: Sergio Munoz (Chile), Marleide da Mota (Brazil), Herminio Hernandez (Peru) and Hortensia Reyes (Mexico).

The network continues to expand its membership. Recently, the Centro Cochrane Iberoamericano (CCI, or Iberoamerican Cochrane Collaboration Center), del Hospital de la Santa Creu I Sant Pau de Barcelona, Spain, became the newest member of the LatinCLEN family. Visit them at <http://www.cochrane.es/English/>

*Sergio Munoz
Outgoing President
LatinCLEN*



Outgoing President Dr. Sergio Munoz with the new President Dr. Juan Manuel Lozano



Participants of the VIII LatinCLEN Regional Meeting, May 28 to 31, 2003, Temuco and Pucón, IX Region, Chile

CanUSACLEN develops plans for collaborative research project

In February, 2003, 23 members of CanUSACLEN participated in a planning meeting at the University of North Carolina in Chapel Hill, North Carolina to develop a collaborative research project. The day-long meeting grew out of the conviction that CanUSACLEN should begin work on one of its missions – to conduct collaborative research among members and sister institutions in the INCLLEN Trust to address inequities in health and health care. The network further wanted to study health conditions that could be improved by evidence-based knowledge exchange and by innovative methods to implement clinical interventions resulting from clinical epidemiologic research (this fits in with the ‘Knowledge Plus’ initiative of INCLLEN Trust). Thus, members of CanUSACLEN intend to develop collaborative research that complements the efforts of INCLLEN Trust and other CLENs.

With this general approach agreed upon, a committee was formed, led by Russ Harris at the University of North Carolina. Members are: Art Evans at Cook County Hospital, Chicago; Andrea Cortinois at the University of Toronto; Carmel Martin at the University of Ottawa; and Bob Fletcher at Harvard Medical School.

After considering many proposals and health conditions, the committee decided to focus on “Improving the Management of Diabetes Mellitus in Underserved Populations in North America”. Diabetes is growing at epidemic rates in Canada and the United States, especially among disadvantaged populations. In addition, diabetes is an important and growing chronic disease problem around the world. There is strong evidence that care (especially management of cardiovascular risk factors) is effective and a large gap exists between expert advice based on evidence of effectiveness and actual care in the community.

The plan is to choose three disadvantaged communities, two from the U.S. and one from Canada. For example, African American and Hispanic communities might be chosen in the U.S. and an Inuit or other Native American population in Canada. By choosing several different types of communities, similarities and differences in the reasons for inadequate care and the effectiveness of interventions across communities can be generated.

Three phases of study are envisioned. Phase 1 involves documentation of causes of poor health outcomes among disadvantaged groups with diabetes by a thorough literature review. Interventions that could potentially improve the outcomes will be identified and developed. Potential study communities will be contacted as well.

During Phase 2, pilot and feasibility testing will be conducted. Interventions will be implemented in small areas and their feasibility, acceptability and likely effectiveness will be determined.

In Phase 3, rigorous study of the effectiveness of interventions will be undertaken. The study will include a control community and the outcomes will likely include glycemic control and global

cardiovascular risk control (including control of hypertension and dyslipidemia).

The interventions the committee is considering draw from global, not just North American, examples. They will be

multi-factorial and will include a self-management-directed approach that likely will include lay health advisers (or peer case managers) who could organize and administer community programs. Community diabetes care teams will be created. These teams will include medical professionals such as primary care physicians, nurses, podiatrists, dietitians, clinical psychologists. Community lay persons will also be invited to the teams. Computerized systems to keep track of patients, produce reminders, make available clinical guidelines (with appropriate links to the evidence base), and give “standing orders” may be developed.

The research team is currently working on identifying others, including a diabetes specialist, who may want to join the project. Several potential funding sources have been identified and plans are being made to submit proposals in the fall of 2003.

Anyone wishing to learn more about CanUSACLEN’s research plans should contact Russ Harris (rharris@med.unc.edu).

Suzanne Fletcher
President
CanUSACLEN



CanUSACLEN members at work



CanUSACLEN members at INCLLEN GM XIX, Kunming, China

Meet CanUSACLEN's newest member – the CERTC at Michigan State University

The Michigan State University (MSU) Clinical Epidemiology Research and Training Center (CERTC) is located in the Department of Epidemiology and the Data Coordinating Center within the College of Human Medicine (CHM). Led by its Director, Dr MH Rahbar (rahbar@msu.edu), the CERTC enjoys a strong environment of collaboration with the clinical departments of CHM including the Department of Family Practice. Further, CHM is committed to medical research, particularly that which benefits its patients and communities. This dedication, as well as the combined resources of the central campus and the community campuses, provides an excellent system in which to perform community-based clinical researches. Michigan State University College of Human Medicine is a community-based medical school utilizing a network of practice sites and hospitals across Michigan.

The Department of Epidemiology offers a doctoral program in Epidemiology, a Master of Science in Epidemiology and a Certificate in Epidemiology. To facilitate distance learning, the department is aiming to develop the capacity to broadcast all core courses by PictureTel to CHM's community campuses. The department also offers the TRECOS (Training Clinical Researchers in Community Settings) Program, a training program for medical doctors who are planning to become clinical investigators. Funded by the NIH, this two-year training program consists of a core of formal coursework in epidemiology, biostatistics and research ethics. It also includes a special research seminar series with nationally recognized clinical investigators and a mentorship arrangement for each trainee with an established clinical and/or laboratory investigator at MSU.

Aside from training, the Department of Epidemiology is also involved in research, which includes the conduct of cutting-edge epidemiological investigations relevant to public health, especially

the public health of Michigan. The linkages of CHM with the medical facilities of six Michigan communities and the Michigan Department of Community Health create numerous opportunities for collaboration in community epidemiologic investigations.

Community-based research is supported by both an electronic infrastructure, which links all six-campus sites, and a network of family practice groups that collaborate in research. The Department has a strong record of obtaining research grants from US federal agencies such as the National Institutes of Health (NIH), The National Institute of Mental Health (NIMH), The National Institute on Alcohol Abuse and Alcoholism (NIAAA), The Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control and Prevention (CDC). It also has a strong record of publishing important scientific researches in major peer-reviewed journals. Current research projects include the etiology and preventability of reproductive and child health disorder, nutritional and cardiovascular diseases, cancer, and communicable diseases, occupational health and the assessment of medical care effectiveness. Some faculty members are developing methodological innovations in epidemiologic modeling, disease mapping, and biostatistical procedures.

The Department provides consultation services in epidemiology and biostatistics to MSU faculty, community health professionals, and public health agencies. It has a Biostatistics Division that handles the statistical consultations. Involvement in consultation depends on faculty interest, time commitments and available resources. Some of these consulting activities have led to on-going collaborative research projects within and outside the University.



*Dr. MH Rahbar
Director, MSU CERTC*

*MH Rahbar
Director
MSU CERTC*

CEUs in Iasi and Bucharest expand clinical epidemiology in Romania

Prof. Valeriu Rusu, Dean of the School of Medicine, University of Iasi in Romania, together with the Vice-Chancellor of the University, signed a new 5-year agreement of collaboration in clinical epidemiology with the Claude Bernard Lyon 1 University, represented and signed by the Dean (Prof. Hélène Pellet) and President of Claude Bernard Lyon 1 University. Cooperation between Iasi and RECIF started eight years ago. During this time, the Iasi CEU grew and became autonomous, having fulfilled the criteria for RECIF membership. It was admitted as a CEU in 2001 with Prof. Doina Azoicai as its director. This CEU works in close cooperation with the CEU in Bucharest and the RECIF-Amiens.

The CEU in Iasi is active in both capacity building and research activities. Prof. Doina Azoicai, Head of the *Centre de Lutte contre les Infections Nosocomiales* (CLIN, Infection Control Committee) of the Iasi Hospital works on nosocomial infections. Dr. Serban Ghiorghiu, an oncologist, is working on a randomized controlled trial which compares gemcitabine and palliative care in lung adenocarcinoma and epidermoid cancer. Prof. and Dean Valeriu Rusu and Prof. Doina Azoicai are collaborating with the Iasi Ministry of Health in its program to teach clinical epidemiology and critical appraisal of the medical literature to second level students of every medical school in the country.

In Bucharest, Dr Cristian Baicus's study on unknown fever etiology in Romania will be published in the *European Journal of Internal Medicine*. Supported by RECIF, this study involved 10 hospitals in Romania and is the first Romanian multi-center study. The results will also be presented in the European Congress of Internal Medicine this year in Berlin, Germany.

Meanwhile, about 1,000 copies of the Romanian translation of the RECIF book "Clinical Research - From research idea to publication" were sold. As of press time, the book, which was released last quarter of 2002 (See *INCLEN News* January 2002), is still in demand. RECIF congratulates Madam Dinescu, a French teacher in the School of Medicine of Iasi, who is responsible for this French-Romanian translation.

*Pierre Duhaut
Coordinator for Romania
RECIF-EuroMed CLEN*

*Anne-Sophie Laréal
RECIF Coordinator
RECIF-EuroMed CLEN*



*Dr. Cristian Baicus
Director, CEU Bucharest*

Réseau d'Epidémiologie Clinique International Francophone (RECIF)- EuroMed CLEN and partners in Gabon and Romania hold clinical epidemiology seminars

RECIF (Réseau d'Epidémiologie Clinique International Francophone) in collaboration with EuroMed CLEN and the "Association des Femmes Médecins Docteurs en Sciences Oeuvrant pour la Santé Humaine" (AFEMDOS, an association of women, doctors in sciences, working for human health in Gabon) conducted a seminar entitled "Introduction to Clinical Epidemiology and Research" in Kango, Gabon on March 31 to April 4, 2003. The seminar was supported by the World Health Organization (WHO) and the Sciences and Health University of Libreville.

and Health of Libreville had been previously identified by his Dean, Professor Paul-Marie Loembe as a potential candidate for further training in Lyon in the field of cancer epidemiology.



Dr Belembaogo and Dr Anne-Marie Antchouey will act as resource persons in clinical epidemiology in Libreville. They will also be involved in the development of a CEU in Libreville.

Meanwhile, a level 2 seminar of methodology in clinical research was held in Iasi, Romania on May 5-10, 2003. Three universities collaborated in this seminar: RECIF-Lyon, represented by its Dean in charge Prof. Hélène Pellet; the Jules Verne University of Amiens, represented by Prof. Pierre Duhaut; and the RECIF CEU of Iasi, represented by Prof. Doina Azoicai who was the Coordinator. Prof. Pierre Duhaut, teacher and coordinator of the Romanian clinical epidemiology cooperation for 10 years, continues to support the Romanian team not only in Iasi but also in Bucharest.



Twelve physicians were trained by Prof. Doina Azoicai (RECIF CEU of Iasi, Department of Epidemiology, School of Medicine, Iasi), Dr. Cristian Baicus (RECIF CEU of Bucharest, Service of Internal Medicine, Colentina Hospital, Bucharest), Dr. Dana Minca (RECIF CEU of Bucharest, Institute of Public Health, Bucharest) and Prof. Pierre Duhaut.

*Anne-Marie Schott
Coordinator for Gabon
RECIF Euro-Med CLEN*

*Pierre Duhaut
Coordinator for Romania
RECIF Euro-Med CLEN*

*Francois Chapuis
President
Euro-Med CLEN*



*Dr. M. Rabilloud, Dr. A.M. Schott,
Dr. A.M. Antchouey and Dr. S. Touzet.*



Opening Ceremonies of the Seminar "Introduction to Clinical Epidemiology and Research"

Twenty clinicians attended the seminar conducted by three French RECIF/EuroMed CLEN members: Dr Anne-Marie Schott (project coordinator), Dr Muriel Rabilloud and Dr Sandrine Touzet.

The Minister of Public Health, Minister of Education, Research and Technological Innovation, WHO representative, Vice-Chancellor of the Sciences and Health University, President for Education of the Council of the School of Medicine, several professors of the School of Medicine, AFEMDOS representatives and authorities of the city of Kango graced the opening ceremony.

Topics covered were: epidemiological methods, study designs, critical appraisal of the literature, evaluation of diagnostic tests, writing a study proposal, medical writing and introduction to biostatistics. In the evenings, there were workshops such as small group discussions on four previously selected potential research projects and hands-on exercises on the EpiInfo software. The four projects chosen in a pre-seminar evaluation were two projects on AIDS, one about cancers in the region of Mounana (location of a former open sky mines of uranium) and one about prevalence of epilepsy in Gabon.

One of the participants, Professor Ernest Belembaogo, Head of the Medical Oncology Department of the University of Sciences

INCLLEN-SEA's EQUAL project moves into second phase

The EQUAL Team (Evidence for Quality in Asia and Australia, the flagship project of INCLLEN-SEA) successfully completed Phase 1 of the project. This first phase critically appraised existing clinical practice guidelines (CPGs) and other related materials on the prevention, detection, and management of tuberculosis in Thailand, Malaysia, Philippines, and Australia. Currently, the team members are writing papers for publication, including a paper on the reliability of the Shaneyfelt and AGREE Instruments in evaluating CPGs. The EQUAL team also finished writing the Phase 2 proposal, which aims to determine effective methods of dissemination and implementation of CPGs on tuberculosis. This proposal includes country proposals from Indonesia, Malaysia, Vietnam, and the Philippines. The team submitted the proposal to local and international funding agencies including the INCLLEN Trust.

In another development, the CERTCs in Thailand (the Thai Consortium) and the Philippines (the University of the Philippines) evaluated their graduate programs in clinical epidemiology. With support from INCLLEN Trust, the CERTCs examined the objectives of their programs, studied individual courses, and reviewed program administration. The CERTCs are now working on curriculum and administrative improvements of the program towards a more relevant graduate program in clinical epidemiology in the region. The CERTCs also submitted a proposal on Distance Learning in Public Health and Clinical Epidemiology to the Association of Southeast Asian Nations – European Union (ASEAN-EU) University Network Program in collaboration with the University of Manchester, United Kingdom and the University of Hamburg, Germany.

With the onset of the Severe Acute Respiratory Syndrome (SARS) epidemic in the region, members of the network participated in the surveillance and infection control activities on SARS. Thailand, Vietnam and the Philippines were active participants in the efforts to assist health care providers in identifying and managing patients suspected and/or infected with SARS. In the Philippines, Drs. Marissa Alejandria and Regina Berba, together with other clinicians, epidemiologists, infectious diseases and pulmonary medicine specialists, participated in the formulation of the SARS Clinical Guidelines for Health Facilities in the Philippines.

The INCLLEN-SEA IX Regional Meeting originally set in June 2003 was rescheduled to November 6 to 8, 2003 in Manila, Philippines because of the SARS epidemic in the region. The Board of Coordinators and the Organizing Committee decided to retain its original theme - Research@thespeedofpolicymaking. Details and other developments can be viewed at www.inclensea.org.



INCLLEN-SEA members at INCLLEN Global Meeting XIX in Kunming, China

*Pamela Tagle
Administrative Officer
INCLLEN-SEA*

Aga Khan University CEU launches Clinical Scholars' Program

The Clinical Epidemiology Unit (CEU) of Aga Khan University, INCLLEN-SEA's latest addition to its fold, launched its Clinical Scholars' Program in May 2003. Under this program, board-certified clinicians who are interested in research will be offered training leading to a Diploma in Clinical Epidemiology. Considering the busy schedule of the clinicians, courses will be taught on a part-time basis, spread to four terms of three months each. The time commitment for classes is 2-5 hours twice a week except during the first semester when there will be 4 sessions every week.

The CEU-AKU also conducted a rigorous two-week workshop on research protocol writing. The workshop targeted faculty and clinical fellows at AKU. The workshop, which shall be offered on an annual basis, was attended by 15 participants. They received training on fundamental principles of research methodology and protocol writing skills.

Details of the Clinical Scholars' Program, course offerings of the unit and application form are available at www.aku.edu or e-mail ceu@aku.edu

*Tazeen Jafar
Director
Aga Khan University
CEU*



Dr. Jafar, Director of CEU, supervising a clinic for patients with hypertension.

Thai CERTC evaluates thesis proposals, improves curriculum

On March 3-4, 2003, the Thai CERTC, also known as the consortium of the CEUs of Khon Kaen University, Mahidol University and Chulalongkorn University, was privileged to have Dr. Mary Ann Lansang, INCLEN Trust Executive Director, as one of the external examiners of thesis proposals of the 11th batch of fellows in clinical epidemiology. Other evaluators were Prof. Alan Geater of Prince of Songkla University, faculty members from the consortium and partners from the Ministry of Public Health.

In addition to valuable recommendations on the fellows' thesis proposals, the fellows themselves had an opportunity to give their feedback on the graduate program. Their feedback was used in a workshop on curriculum improvement held during the consortium's annual retreat at Phu Pha Num resort in Loie province on March 22-23, 2003. Thirty one ThaiCLEN faculty members, fellows and support staff members participated.

For more than a decade, Thai CERTC members have remained steadfast in their commitment to produce qualified graduates and high quality research papers. The Thai CERTC's master's degree program has continuously attracted foreign and local students. For this upcoming academic year 2003, which commences on June 2, 11 fellows have been accepted representing different specialties and health institutions.

With the overflowing responsibilities and activities of our two senior Thai CERTC executive committee members, and to pave the way for junior members to serve, Associate Professor Dr. Sumitr Sutra has stepped down and Professor Pisake Lumbiganon has taken over as the new Khon Kaen CEU Director and Thai CERTC Co-Director. Dr. Kingkaew Pajaree takes the position as Head of the Secretariat in place of Dr. Siriporn Pitimana-aree.

Visanu Thamlikitkul
Director
Thai CERTC

Awards

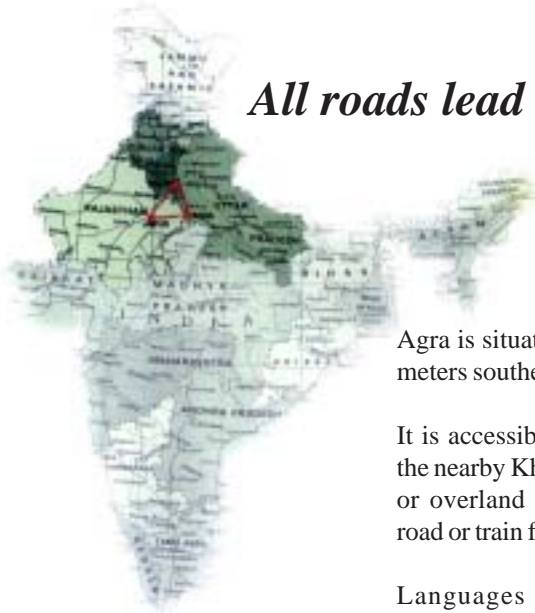
Dr Michael Dibley of the Centre for Clinical Epidemiology and Biostatistics, University of Newcastle, was awarded an adjunct Professorship by the School of Public Health, Xi'an Jiatong University, Xi'an, China in recognition of his contributions to research on the effects of multi-micronutrient supplements on various pregnancy outcomes, including birth weight. These supplements will be compared to iron-folate supplements.

Awards for Excellence in the Field of Teaching and Research were presented to **Associate Professor Kate D'Este** and **Dr. Jon Adams** by



the University of Newcastle on May 8, 2003. Named by peers and students as a "born educator", Dr. D'Este has a proven track record in educating not only her students but also her colleagues in the art of biostatistics. Named "a teaching dynamo", Dr. Adams brought a new field to the University of Newcastle, the Complementary Alternative Medicine. Dr. Adams is the co-editor of a soon to be released book entitled "*The Mainstreaming of Complementary and Alternative Medicine – Studies in Social Context*". **Long Service Awards** were presented to **Associate Professor Julie Byles**, **Ms Maya Guest** and **Ms Rhonda Walker**.

All roads lead to Agra



Agra is situated 220 kilometers southeast of Delhi.

It is accessible by air via the nearby Kheria Airport, or overland transport by road or train from Delhi.

Languages spoken are Hindi, Urdu, and English

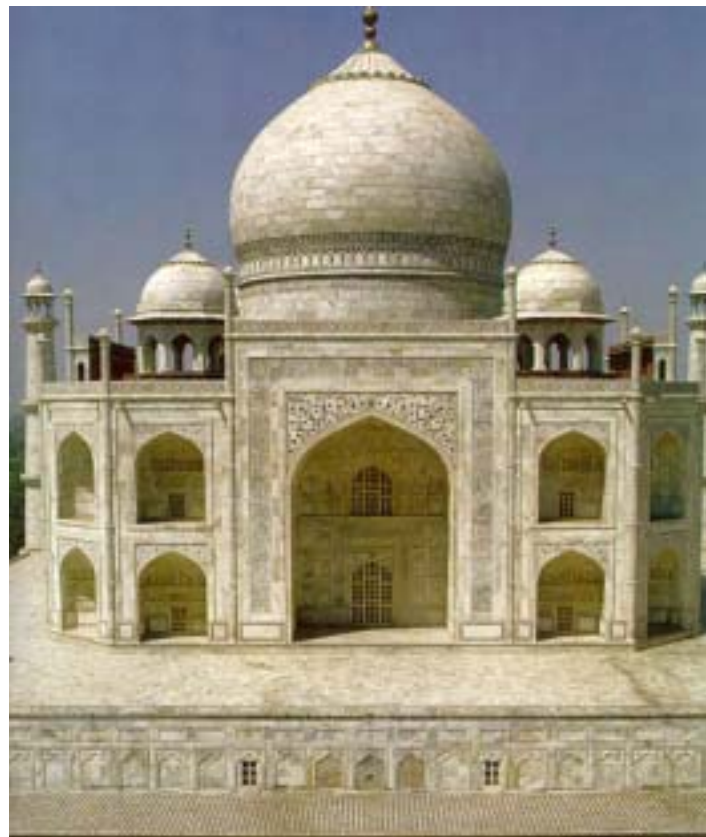


Just a few kilometers away from the ancient monuments and fortresses of the Mughal Emperors, the INCLEN Global Meeting XX venue, Jaypee Palace Hotel and Convention Centre boasts of world-class guest and conference amenities housed within artful surroundings that echo the splendor of India's rich cultural history.

INCLLEN Global Meeting XX to be held in Agra, India

The INCLLEN Trust and IndiaCLEN are pleased to report that preparations for the INCLLEN Global Meeting XX are underway. IndiaCLEN will be the host and primary organizer of the GM XX, which will be held on February 11 -14, 2004 in the majestic city of Agra, India. The theme of the meeting is “Leveraging Research through Policy and Practice.” It is consistent with the thrust of INCLLEN of equity in global health research in the context of policy making and practice. Aside from the usual researchers, experts and pillars in the formulation of health policies and implementation as well as global health and development decision makers will be invited to enliven the topics and discussions.

The INCLLEN GM will be coming to India for the second time. This country of dynamic culture and ancient history had been the successful host of the GM VII held in Goa, India in 1989. This time, meeting participants will be accommodated at the Jaypee Palace Hotel and Convention Centre in Fatehabad Road, Agra. The hotel is an architectural marvel that is a monumental tribute to the greatness of the Mughal Emperors of India. The city of Agra houses monuments and fortifications built by the Mughals. It is the location of the world-famous Taj Mahal, one of the wonders of the world. An exquisite structure of white marble, Taj Mahal was built by the greatest of the Mughal emperors, Shah Jahan, to enshrine the body of his beloved wife Mumtaz Mahal. The city would be a perfect backdrop for the GM XX for it offers history and culture set in the ever-changing context of health and policy issues.



Agra is the site of one of the seven wonders of the world, and one of the world's most famous landmarks, the Taj Mahal.



India is undoubtedly a prime destination for cultural tourism with the diversity of its land and peoples.

Interested applicants are invited to submit abstracts of completed studies in line with the theme of health research policy and practice. Abstracts in the areas of clinical epidemiology, biostatistics, health economics, health social science, field epidemiology and environmental health are also welcome. Abstracts will be judged

on relevance to the theme of the meeting, relevance to other global and regional research priorities, scientific rigor and ethical merit.

The Chair of the overall organizing committee is Dr. Ramesh Ahuja, Director of the CEU in King George's Medical College. Dr. Narendra Arora and Dr. Kurien Thomas are Chair and Co-Chair of the Scientific Committee, respectively. GM XX is supported by the INCLLEN Trust, INCLLEN, Inc., the USAID and the Rockefeller Foundation. For details, visit www.incllen.org, www.indiaclen.org or e-mail the IndiaCLEN office at: indiaclen@touchtelindia.net or the Lucknow conference secretariat at: kgmce@satyam.net.in

*Ramesh Ahuja
Chair
Organizing Committee, GM XX*



India's national bird, the peacock.

Plenary session topics:

- Rational Drug Use and Essential Medicines
- Disease Control Priorities Project (DCPP)
- Preview of World Health Report 2004 on National Health Research Systems
- Infant and Child Health Research Priorities

INCLLEN Africa VIII sets the stage for a new era in INCLLEN-Africa's history

INCLLEN-Africa (IA) VIII, this year's annual meeting of the regional network in Africa, was held on May 28-30 in Entebbe, Uganda. Considered as one of the most important meetings since the inception of IA, the meeting set the stage for a new era in the life of the regional network. Recognizing the need to develop a regionalization model that would stimulate strong networking within IA and with networks of like-minded professionals in the continent and in the world, the IA Council decided to make this meeting not only a scientific conference but also a strategic planning workshop. The workshop, which involved all the participants, aimed to identify new directions for the network. It also aimed to develop a work plan to utilize available resources as leverage for expanded activities and assure the network's sustainability.

The theme of the meeting, "Partnerships for Health Research and Development", symbolized the most important challenge facing IA: to harness the strengths of its human resources and the strong structure of its CEUs in the light of the growing focus on health research and development in Africa in order to improve the health and lives of the African people.

On May 26-27, the Council met to discuss, among others, the difficulties and challenges facing IA as well as the pro's and con's of regionalization. The network's mission and goals were also reviewed. The Council arrived at a consensus that there is a need for IA as a network and that its mission and goals should be restated. Further, the Council proposed resolutions to modify the structure of the network that will encourage involvement of the members, improve the network's operations, promote communication and transparency of the offices and leadership at all levels. These were then presented at the General Assembly.

Discussions at the General Assembly included the reasons underlying the sluggish progress of IA and possible solutions. The participants emphasized the need to adjust the structure and operations of the organization to allow better flow of information, transparency and maximum involvement of the members in

decision-making and activities. They also expressed the importance of revising the constitution to ensure accountability at all levels, to facilitate decision-making and dynamism of the Council, and to conform to the new directions presented by the Council. The General Assembly affirmed the decision of the Council that a functional regional structure is needed and approved the new mission and directions of IA. Further, the General Assembly, reiterated the importance of working together to revitalize the network and to use the available funds to leverage sustainability for the network.

At the opening ceremony, the guest speaker Prof. Oladapo Walker, WHO representative in Uganda, presented prospects for research and research collaboration in Africa, highlighting numerous opportunities. Prof. Walker stressed that the setting of clear goals and the determination to realize the priorities of Africa by persistent African researchers are the keys to success.



The keynote presentations by Prof. Nelson Sewankambo, Dr. Mary Ann Lansang and Prof. Rapheal Owor covered different aspects of the main theme. Prof. Sewankambo reviewed the prospects and challenges of partnerships in health research. While realizing the need and power of collaboration, he also acknowledged the

difficulties and called for better evidence for the effectiveness of partnerships. Dr. Lansang presented an overview of international collaborations in health, forms of partnerships and challenges, rules of engagement and a mapping of regional collaborations, including specific options for IA. Prof. Owor presented the experience of the African Health Research Forum. He outlined the stages of developing a partnership from the definition of research priorities to the dissemination and implementation of findings. These talks guided IA's leaders and members in their attempts to find a new direction for IA and identify the challenges and ways towards revitalization of the network.

In the scientific sessions, participants from 5 of the 7 member CEUs presented results of their projects in health care and

development. The presentations showcased the diverse and complementary nature of IA.

The Leadership and Management Program (LAMP) Workshop took place on the second day of the meeting and was open to all attendants. Facilitated by Dr. Lansang and Dr. James Hakim, the workshop included short lectures and participatory exercises. The topics covered were team building and strategic planning, two leadership skills much needed at this stage of development of IA. The materials presented and the exercises allowed the participants to reflect on the situations in their own respective CEUs as well as the network as a whole.

One of the most productive activities of the meeting was the proposal writing session. At this session, three groups identified a topic of interest from a list of Requests for Proposals collated by the Council. The groups worked on a concept paper on their chosen topic, which they later presented in a plenary session. Further, the groups committed to develop these concept papers into full proposals for submission to funding agencies.

By the end of the meeting there was a sense of satisfaction with the achievements attained and a renewed commitment from the Council and the members to work together to make a difference in the health care and development of the African people. Just before the closing ceremonies, the new officers of IA were then sworn to office by Dr. Lansang. The duly elected officers were: Dr. Charles Karamagi, the new IA Chair, and Dr. Amr Hassan, who was confirmed as IA Secretary-General.

The dedication of the organizing committee from Makerere University CEU under the leadership of its Director, Dr. Charles Karamagi and the support of Prof. Nelson Sawenkambo, Dean of the Makerere School of Medicine, made this meeting a successful event. The trips to the source of the Nile at Jinja and the closing ceremony featuring traditional music, singing and dancing added an authentic Ugandan flavor to the meeting.

Continuous help and support offered by Dr. Lansang, Executive Director of INCLLEN Trust, and the team at the INCLLEN Executive Office were instrumental in keeping IA going. On behalf of the IA Council, I would like to extend our thanks to Dr. Lansang and her team and to all those who contributed their time, wisdom and commitment in making this meeting a success and in committing to make INCLLEN-Africa as one of the strong links in the chain of INCLLEN.

Amr Hassan
Secretary General
INCLLEN Africa

Pretoria Clinical Epidemiology Unit graduates first batch of M.Sc. Clinical Epidemiology students, forms partnerships for research

The Pretoria Clinical Epidemiology Unit (Pretoria CEU) reaches a milestone this year with the graduation of its first batch of 4 students in Master of Science in Clinical Epidemiology. Another 10 students are in various stages of their studies. The CEU is also proud to announce that one of its students was selected to attend a cardiovascular clinical epidemiology course in Canada.

To further strengthen its training objectives, Pretoria CEU continues to build up its faculty pool. Later this year, Dr. Miriam Sturkenboom of Erasmus University, Rotterdam will be a guest lecturer in Analytical Epidemiology. Prof. Paul Rheeder, the Unit Director, who is currently undergoing his PhD training at the Utrecht University, is scheduled to defend his thesis entitled "Obesity and diabetes complications in black South African women" in Utrecht, The Netherlands on September 15 this year.



Dr. Charles Karamagi, new Chair of INCLLEN-Africa signing his oath of office

Partnerships and collaborations with other institutions are also being forged to keep the CEU's research activities in motion. It participated in the INCLLEN/WHO resource utilization study. A fruitful partnership has been formed with the Genomics Research Unit of the University of Potchefstroom in South Africa and the University of Dresden which has led to studies regarding the genetics of Type 2 diabetes. The Unit will also collaborate with Utrecht University on the imaging of atherosclerosis.

The University of Pretoria has funded an ultrasound system for vascular evaluation. This will make it possible for the Pretoria CEU to collaborate with the Department of Internal Medicine and the Department of Radiology to conduct interdisciplinary research on the evaluation of the extent and localization of atherosclerosis among black and white subjects with myocardial infarction or stroke. The Unit continues to be involved in projects on other areas of interest including pharmaco-economics, psychological aspects of chronic diseases as well as screening for diabetes complications and cardiovascular risk factors.

The Unit is keen on expanding its training and research capacities and hopes to bring its outputs and relevance to new levels.

Paul Rheeder
Director
Pretoria CEU

Research and training programs move forward at the University of Zimbabwe CEU

In 2002, the University of Zimbabwe Clinical Epidemiology Unit (UZ-CEU) was given financial support by the Centers for Disease Control and Prevention (CDC), Atlanta, USA, to embark on the HIV/AIDS Quality of Care Initiative or HAQOCI (see *INCLEN News* July 2002). For this project, the CEU received technical assistance from the CDC-Zimbabwe AIDS Program. Several activities and programs identified and outlined at a national stakeholders' meeting in February 2002 have been planned and implemented.

One of these activities was the Baseline Survey on HIV/AIDS Quality of Care Situation Analysis which aimed to understand the care issues surrounding HIV/AIDS in Zimbabwe. Tools for collecting both health institution- and community-based data on HIV/AIDS care and support were developed, pilot-tested and finalized. Surveyors were trained on data collection techniques prior to conducting the main survey in August-September 2002. The findings of this survey will provide critical inputs to the development of appropriate responses for improving the quality of care of HIV/AIDS patients in the country.

As part of its information dissemination efforts, the HAQOCI developed materials including newsletters for policy makers, pamphlets and brochures for the public, and a video on home-based care targeting both patients and health care providers.

HAQOCI also implemented the Opportunistic Infection Prevention Program (OIPP). This program addresses both training and infrastructure needs to combat the problem of opportunistic infections. The first training, conducted in September 2002, was participated by 28 nurses and doctors from the Harare Central Hospital. While training modules still need to be developed, the overall plan of OIPP is for all health care providers in Zimbabwe to receive this training.

The Opportunistic Infection Prevention (OIP) Clinic, the other component of the OIPP, is being piloted in Harare. The clinic aims to strengthen the referral system for HIV/AIDS clients, offer counseling and provide IEC materials. The Zimbabwe government has committed itself to provide basic infrastructure if the concept of the OIP Clinic can be demonstrated to be replicable in other sites.



Data entry in progress

Another component of the HAQOCI is the development of National Standard Treatment Guidelines (STGs) for HIV/AIDS and training on Discharge Planning of Chronically and Terminally Ill Patients. The STGs are needed to minimize ineffective interventions, waste of

resources and harm to patients. Discharge Planning, on the other hand, is aimed to establish a continuum of care for patients suffering from HIV-related illnesses as they are transferred from the health facility to their homes. Both efforts are seen to ease the burden on the country's health care budget and resources.

UZ-CEU extends its appreciation to the CDC for its support of the above project activities.

In another development, The Faculty Board and the Academic Board of the University of Zimbabwe has recognized the UZ-CEU as a training center in clinical epidemiology. As a training center, UZ-CEU offers the

Masters in Clinical Epidemiology Program by distance learning (See *INCLEN News* July 2002 issue). The first batch of 22 candidates was registered in 2002. Currently, UZ-CEU is working on its application as an INCLEN (CERTC) Clinical Epidemiology Research and Training Center.

The 3-year program primarily targets health professionals in the African region. On the first year of the program, candidates learn basic tools of epidemiology and biostatistics. On the second year, candidates develop research proposals. They also undergo training in health social sciences, clinical economics and clinical epidemiology. On the third year, the candidates conduct a research project of their choice and submit their dissertations.

Aside from the graduate program, the UZ-CEU annually conducts a course on research methods for the faculty staff and postgraduate students of the university. A research methods booklet, which would standardize the teaching of this course, is currently in the process of development.

Rose Kambarami
CEU Director
University of Zimbabwe



Dr. C. E. Ndlovu, UZCEU member and National Drug and Therapeutics Advisory Committee (NDTPAC) Ministry of Health Chairperson



Some members of the first cohort of fellows of the Masters in Clinical Epidemiology Program

Research

How can Clinical Epidemiology help assess effectiveness efforts to reduce inequities in health? Special methodologic challenges

A workshop at INCLLEN Global Meeting XIX in Kunming, China

Suzanne Fletcher, Harvard Medical School, Boston, USA

Vivian Robinson, University of Ottawa, Ottawa, Canada

Laura Sadowski, Cook County Hospital, Chicago, USA

Peter Tugwell, University of Ottawa, Ottawa, Canada

In many countries, life expectancy has reached a new high, and infant mortality a new low. These averages however, obscure an uneven distribution of health, with health declining with socio-economic status. Given this inequity, there is increasing recognition that clinical epidemiologists need to consider the impact of interventions on health equity.

An international group is developing a methods interest group on Health Equity within the Cochrane and Campbell Collaborations. This group is looking at which interventions enhance health equity by assessing if such interventions: 1) reduce the rich-poor gap (and the gap across other socio-demographic factors) or 2) improve the health of the poor and most disadvantaged. [See related INCLLEN initiative, the Knowledge Plus Program, on page 3.]

At this workshop at the INCLLEN Global Meeting XIX in Kunming, participants worked in 3 small groups to discuss 2 questions related to clinical epidemiology and health equity.

The first question asked was “How to define the term disadvantage?” As a spring board for discussion, an acronym for defining disadvantage called PROGRESS (for P-place of residence, R-race/ethnicity/culture, O-occupation, G- gender, R-religion, E-education, S-socioeconomic status, S-social capital and resources) was given to the groups. Developed by Hilary Brown and Tim Evans at The Rockefeller Foundation, PROGRESS serves to illuminate the multi-dimensionality of the term disadvantage in terms of both access to care and health status. PROGRESS is currently being used by the Global Equity Gauge Alliance (www.gega.za.org) and the proposed Cochrane/Campbell Health Equity Interest Group.

The primary recommendations from the working groups were to adapt the definition to include the following concepts: perspective, stigma associated with certain diseases, and ecological and political dimensions. The perspective from which the definition is arising is important. The groups also suggested that surveys be done of potentially disadvantaged groups to determine their perception of disadvantage and health equity. The participants also suggested that stigma associated with certain diseases like mental illness, physical disability and HIV/AIDS needs to be incorporated in the PROGRESS acronym, particularly under social capital and resources. Ecological and

political dimensions of equity, not captured in the PROGRESS acronym, need to be considered when trying to enhance health equity.

The second question focused on how to choose a study design to assess effectiveness and equity and what special issues need to be addressed. Recommendations from the working groups were to: consider implementation factors to improve uptake into clinical practice, especially for disadvantaged populations (this includes working with policy-makers, NGO’s and all relevant stakeholders); combine both qualitative (e.g., ethnographic case studies, focus group discussions and process evaluation) and quantitative study designs to capture important dimensions and be able to explain differences in treatment effectiveness across groups; and consider the importance of issues in the recruitment of patients. For example, researchers need to consider the place, time and setting where participants are recruited. Are these recruitment guidelines realistic for recruiting the disadvantaged population/s of interest?

In conclusion, PROGRESS is a good starting point for defining disadvantage. In assessing equity-effectiveness, multidisciplinary teams in collaboration with important stakeholders, such as policy-makers and NGO’s, need to use different study designs (both qualitative and quantitative) and apply special methods to recruit the populations of interest. Measurement of differences needs to consider the clinical importance (not just statistical significance) of both individual variation and differences between groups of people.

Upcoming CLEN Regional Meetings



The **IndiaCLEN Annual Meeting** will be held in Lucknow, North India on September 23-26, 2003. This year’s theme is “Partnerships for Public Health in India”. For more information visit www.indiaclen.org or e-mail: indiaclen@touchtelindia.net



The **INCLLEN-Southeast Asia IX** is scheduled on November 6-8, 2003 in Manila, Philippines with the theme “Research@thespeedofpolicymaking”. For details and updates visit www.inclensea.org or e-mail: coordinator@inclensea.org or AdministrativeOfficer@inclensea.org

Research

Invasive Bacterial Infection Surveillance (IBIS) study group presents 10-year data, additional 3-year Indian Council of Medical Research (ICMR) funding highly probable

The Invasive Bacterial Infection Surveillance (IBIS) study, a project supported by USAID through INCLEN, has completed 10 years of surveillance on vaccine-preventable invasive bacterial infections on *S. pneumoniae* and *H. influenzae* in India.

Dr. Kurien Thomas, IBIS Coordinator, Dr. M. L. Lalitha, coordinator for microbiology and Dr. Mark Steinhoff, project consultant, presented the results of the study at the "Indo-US Collaborative Meeting on Strategies to Reduce the Burden of Acute Lower Respiratory Infection in India". Held in New Delhi on March 10-11, 2003, the meeting was sponsored by the Indian Council of Medical Research (ICMR). One of the important recommendations in this meeting is that the surveillance of diseases due to *H. influenzae* and *S. pneumoniae* should continue. Further, to better understand the burden of these diseases in the country, the surveillance must employ new diagnostic techniques like antigen detection using PCR and Latex tests for meningitis patients, in addition to conventional methods. Given these recommendations, IndiaCLEN has submitted a proposal to ICMR to extend the IBIS study. It is expected that the project will be granted funding for 3 more years through the national budget with a target to initiate by January 2004.

The first IBIS project involved a total of 5,798 patients and 314 bacterial isolates in 3 years. Data regarding pneumococcal disease from this project, the first multi-center pneumococcal data in India, was published in the *Lancet* in 1999 in an article entitled "Prospective multi-center hospital surveillance of *Streptococcus pneumoniae* disease in India". The data on *H. influenzae* was published in the *Clinical Infectious Diseases* in 2002, "Are *Haemophilus influenzae* infections a significant problem in India? A prospective study and

review" (See abstract in *INCLEN News* July 2002 issue). In addition, the study has generated more than 15 peer-reviewed publications in various national and international journals.

The IBIS data from 1993-2002 generated the following findings: pneumococcal resistance to penicillin is fairly low in the Indian subcontinent with an increasing trend that warrants continued surveillance; both *H. influenzae* and pneumococcus show high level of resistance to co-trimoxazole, the drug currently recommended for the ARI-Pneumonia Control Program; use of the nasopharyngeal swabs among school children is a potential rapid strategy for surveillance of antimicrobial resistance patterns; and the currently available 7-valent pneumococcal vaccine provides low level (approximately 40%) coverage of serotypes that cause invasive pneumococcal disease in under 5 year-old children, while the proposed 11-valent pneumococcal vaccine will provide nearly 80% coverage of strains found in Indian children.

IBIS, being a collaboration among IndiaCLEN's 6 CEUs and CERTCs and a flagship study of IndiaCLEN, has facilitated initiation of other successful collaborative researches among these 6 CEUs/CERTCs.

The 10-year data of the IBIS Study has been recognized by health authorities in India as an important contribution for national policies on vaccine and drug use. The continued funding from the ICMR New Delhi is a milestone in national recognition for the high quality work that has been going on for the last 10 years in IndiaCLEN.

Kurien Thomas
IBIS Coordinator

Canadian Institutes of Health Research (CIHR) awards INCLEN and University of Ottawa a study grant on knowledge translation

In line with the INCLEN Trust's Knowledge Management Program, Peter Tugwell and Mary Ann Lansang (INCLEN Trust) in collaboration with INCLEN members and colleagues from the University of Ottawa, got the nod from the Canadian Institutes of Health Research to embark on a project entitled "An International Study of Health Research Funding Agencies' Support and Promotion of Knowledge Translation in Low- and Middle-Income Countries." This project aims to determine effective strategies used by funding agencies to promote the uptake of new knowledge for improvement of health and health equity. The collaborative study involves INCLEN members from Colombia (Dr. Juan Lozano), Brazil (Drs. Jose Quirino and Marcos Ferraz), the Philippines (Profs. Rachel Delino and Cynthia Cordero), Thailand (Dr. Visanu Thamlikitkul), India (Drs. L. Jeyaseelan and Shuba Kumar), South Africa (Dr. Jacobus Louw) and Canada (Drs. George Wells and Vic Neufeld). Both national and international funding agencies (e.g., World Bank, Wellcome Trust, WHO-TDR and CIDA) that fund projects in these countries will be interviewed to identify areas of good practice.

Co-investigators Dr. Jeremy Grimshaw and Dr. Ian Graham, are working on a parallel study in North America, Europe and Australia. They are advising the INCLEN team on methods for quality assurance, translation issues, designing, conducting and analyzing semi-structured interviews with the funding agencies. Analysis of the data will be conducted collaboratively. Country investigators will work together to develop a common code-book of themes arising from the interviews. To share the results with funding agencies, country investigators will hold local debriefing workshops with national and international funding agencies to share lessons learned and areas of best practice. The results will be discussed and presented at a pre-conference workshop at the INCLEN Global Meeting in February 2004.

Vivian Robinson
University of Ottawa

Partners

WHO, COHRED, GFHR National Health Research Systems (NHRS) Initiative generates NHRS work plans

In October 2001, the Council for Health Research and Development (COHRED) together with the World Health Organization and Global Forum for Health Research launched its own initiative to contribute to the ongoing global assessments of health research systems. Coordinating this activity is the Working Group on National Health Research Systems (WG/NHRS), one of the working groups organized by COHRED to address specific issues regarding the different aspects of a Health Research System or HRS (see *INCLLEN News* January 2002).

The WG/NHRS divided its task into two phases: assessment of the NHRS's and the development of a work plan to improve and strengthen them based on the findings of the assessment. Participating in this activity were eight countries: Brazil, Cuba, South Africa, Tanzania, Lao/PDR, Indonesia, Philippines and Thailand. Respective country assessments were conducted from October 2001 to July 2002 using tools and frameworks each country saw as practical and feasible given the timeframe and available resources and materials. In June 2002, representatives from the participating countries met again in Bangkok to give updates on their assessments and share their experiences.

While a definite framework for assessment was not recommended, certain key aspects of an HRS were generally appraised, such as: leadership structure and management, research manpower, resources, process of setting research priorities, ethics in research, and evaluation and monitoring. South Africa used the seven elements of the Essential National Health Research (ENHR) strategy to determine gaps within its health system. Thailand focused on management and governance issues, while Tanzania highlighted the functions of the Tanzania National Health Research (TANHER) Forum in bringing together all its HRS actors and using this as the venue for assessing the system.

The methods applied included the ff.: review of existing literature and relevant materials on laws and policies that have been passed

to support the HRS, mailed questionnaires (as in the case of Indonesia), focus group discussions and in-depth interviews (Indonesia, Tanzania, Philippines), and Strengths-Weakness-Opportunities-Threats (SWOT) analysis (Tanzania, Philippines, Thailand, Cuba).

The status of HRS's in these countries varied. As a focal coordinating mechanism for health research activities, Indonesia has the National Institutes for Health Research and Development while Thailand has the Health System Research Institute. In almost all of the participating countries, the ENHR strategy was adopted by the Ministries of Health and served as a guide in allocating resources, identifying research priorities, networking, and strengthening research capacities. On the other hand, Lao/PDR did not have yet an established HRS but it has formulated strategic plans to develop the system and identified its primary goals. Overall, the countries were able to identify gaps and weaknesses in their HRS's leading to the development of appropriate work plans.

Cuba, Indonesia, South Africa, Tanzania and Thailand chose to strengthen the existing structures already in place in their health systems. Brazil planned to create an NIH-type of agency within the MoH to organize its HRS. The Philippines, after consultation with stakeholders, voted to shift the stewardship function of the HRS from the Department of Health to another government agency, the Department of Science and Technology, through the Philippine Council for Health Research and Development. Lao/PDR joined the ongoing HRS activities by establishing an Ethical Review Committee (ERC), which would also coordinate the development of the country's HRS and national guidelines.

Alberta Vargas
Research Associate
Assessment of National Health Research
Systems Project

Equity and Clinical Epidemiology (from page 1)

Within Canada, and internationally, there is increasing interest in "knowledge translation": translating research evidence into improved health for the population. Knowledge translation involves identifying barriers and tailoring information for different users of research results with the goal of increasing implementation of effective interventions.

Dr. Tugwell described several exciting initiatives that are underway globally that involve both action-oriented epidemiology and knowledge translation of research evidence to improved health. Three examples are described below.

The Global Equity Gauge Alliance (www.gega.za.org) has developed an approach based on 3 pillars including measurement, advocacy and community mobilization. This approach involves

bottom-up participation from the community as well as top-down from policy-makers. Dr. Tugwell and the University of Ottawa are in the process of developing a local Ottawa Equity Gauge based on this very successful model developed in low- and middle-income countries (LMIC).

The University of Ottawa, led by Dr. Annette O'Connor, has developed the health coach approach to engage disadvantaged women in shared decision-making. This approach includes assessing individual decision-making needs and coaching women to find the evidence-based information they need, clarifying their values and developing the communication skills needed to make and act upon their decisions. This approach has been evaluated in Chile, with funding from the Canadian International Development (to page 21)

Partners

Development of Integrated Disease Surveillance Program (IDSP) in India: A successful IndiaCLEN-Government of India partnership

Disease surveillance is considered as the backbone of public health programs in India. It is important in the early detection of epidemics, monitoring of disease control programs and optimum allocation of health resources. It also provides information for evidence-based health care, and is an effective health advocacy tool.

The government of India has recognized the potential uses and advantages of disease surveillance. Thus it requested IndiaCLEN to be a partner in the development of an Integrated Disease Surveillance Program (IDSP) in the country. During the last two years, IndiaCLEN members participated in the developments of the following program components: Project Concept Document (PCD); Project Implementation Plan (PIP); User-friendly Manuals for the districts and their peripheries; and the Training Plan, Strategy and Training Manual.



Participants of IDSP workshop on development of user-friendly manuals

Sitting: L-R : Dr. RR. Katti – MOHFW Maharashtra, Dr. R.C. Ahuja – Lucknow, Dr. Sunita Shanbag – Mumbai, Dr. Nalini Ramamurthi – Chennai, Dr. Sharada Suresh – Chennai, Dr. Kurien Thomas – Vellore, Dr. Brij Bhushan – MOHFW New Delhi
Standing L-R: Dr. Hemant Kumar – WHO, Dr. N.K. Arora – AIIMS, Dr. A.C. Dhariwal – NICD, Dr. P.P. Joshi – Nagpur, Dr. Devadasan – WHO, Mr. S. Ganeshan – Vellore

A bottom-up approach was carried out by the network to develop the important elements of surveillance in IDSP. A number of state-based workshops were successfully conducted to understand the current surveillance activities. Crucial to the program and its components was the close coordination with state health officers, grass root level health workers in various states, officers of National Institute of Communicable Diseases, Indian Council of Medical Research, World Bank, World Health Organization and United States Agency for International Development .

The program expects to improve the communicable and non-communicable surveillance activities for a limited number of conditions of public health importance in the country. It will be a decentralized, district-centered, action-based system involving private and public health sectors in the rural and urban settings. It will integrate the surveillance related activities of existing vertical programs like the National Polio Surveillance Program (NPSP), Program on HIV/AIDS and Tuberculosis, Malaria and Leprosy Programs.

IDSP plans to integrate and strengthen surveillance activities particularly in administrative reorganization of the surveillance set-up. For example, sharing of information can take place at the district level. The program also aims to strengthen public health laboratories, optimally use information technology and enhance human resource development.

Implementation of the program will be conducted in phases with initial funding from the World Bank. Eight states will be included in the first phase. All 35 states in the country will be included in the program in the next two years.

IndiaCLEN will continue to be involved with the program in facilitating administrative reorganization for integration; strengthening laboratory, communication and computing facilities; participating in human resource development; helping with implementation in different states; and evaluating the program after implementation.

*Kurien Thomas
IDSP Coordinator*

The spectacular Mughal Court at the Jaypee Hotel and Convention Center offers a rare sight of bejewelled architectural splendor.

The palatial venue of the INCLIN Global Meeting XX provides participants with a stimulating blend of modern amenities with the best of cultural antiquity. The hotel is situated only two and a half kilometers away from the famed Taj Mahal.



INCLLEN and partners provide learning modules on “Health Research for Policy, Action and Practice”



Alliance for Health Policy and Systems Research

INCLLEN, the Alliance for Health Policy and Systems Research (AHPSR), the Council on Health Research and Development (COHRED) and the Global Forum for Health Research (GFHR) have collaborated on the development of modules on *Health Research for Policy, Action and Practice*.

The goal of this Collaborative Training Program is to support strategies to increase the impact of health research on policy, programs and practice through training and institutional development. The modules focus on practical experience and best practices regarding health research priority setting, knowledge management, and leadership and advocacy. Designed in a flexible way and tailored to the needs and interests of diverse constituencies, the modules are seen to benefit many people who are interested in increasing the impact of health research. In particular, research managers, policy analysts within ministries of health and research and continuing education officers may find that training in these subject areas will be a valuable investment.

The 3 sets of modules are:

Module 1: *Priority Setting for Health Research*, which discusses various models and methods for setting health research priorities. This portion highlights the experience of countries and organizations that have used these models. Consideration is given not only to priority setting *per se* but also to the implementation of the research priorities.

Module 2: *Knowledge Management and Health Research*, which comprehensively discusses the revolutionary changes that have taken place with knowledge and information during the last two decades and the effect of such changes on the global use and translation of knowledge.

Module 3: *Advocacy and Leadership*, which focuses on the role of advocacy and leadership in strengthening the links between health research and equity in development.

These modules are available at the websites of the collaborating organizations:
INCLLEN Trust: www.incllentrust.org
AHPSR: www.alliance-hpsr.org

COHRED: www.cohred.ch

GFHR: www.globalforumhealth.org

CD-ROM copies of the CTP modules as well as the INCLLEN LAMP (Leadership and Management Program) modules are also available on request. Write to: incllen@incllentrust.org

Your Opinion Counts!

Journal of Clinical Epidemiology

Official Journal of the International Clinical Epidemiology Network?

Imagine this: *Journal of Clinical Epidemiology* (JCE), Official Journal of the INCLLEN Trust. This means INCLLEN at the top of the pack – main contributor to THE Journal, calling the shots for clinical epidemiology all over the world, blazing paths and setting new directions. It’s possible, you know. In fact, a mutually beneficial agreement between JCE and INCLLEN is in the early stages of incubation. Ready or not, this may soon become a full-blown proposal.

But before we get carried away by our ambitions, imagine the potential downside: meticulous methodology to withstand international scrutiny, frantic writing to meet editorial deadlines, cumbersome English editing, subscription fees for all members or membership fees for INCLLEN that covers the subscription. Is this something we really want to do? Is there really potential for a mutual benefit package that is acceptable for all concerned? These are just some of the decisions we need to face.

The INCLLEN Trust would appreciate your reactions, opinions and suggestions. Please write to the Editor, *Journal of Clinical Epid...* ooops, I got carried away by the future. Just write to: incllen@incllentrust.org. We look forward to your comments!

Antonio Dans
University of the Philippines
CERTC

Social inequities . . . (from page 4)

Research can identify disparities in health status. Epidemiological studies can help to identify at-risk groups hidden in aggregate data. Research can determine the causes of disparities through analytical studies that explore why disparities exist. Research that involves evaluations of specific interventions or policies can help inform actions to reduce disparities. Further, research can monitor trends towards equity. For example, household surveys can assess health perceptions and access to care. Facility-based surveys can assess quality of care, while health resource flows can analyze health expenditures.

There are indeed many opportunities for research in addressing equity. What has been achieved so far? What are the gaps? Current studies focus primarily on documenting inequities and the process of trying to correct them but empirical evidence about the effectiveness of strategies to reduce inequities is lacking. For example, interventions such as immunization uptake may result in overall benefit but may not reduce or may even increase inequalities. Further, data on possible harms, costs and priorities of recommended policies to reduce inequities are required. "Common sense" policies may have adverse effects (e.g., social work services for delinquent boys in the UK increases re-offending and substance abuse). Systematic reviews of the effects of interventions are urgently needed since partial or selective citation of evidence is widespread.

To conclude, inequities related to socio-economic status are large and getting larger. The initiatives that we have witnessed in the last 25 years point to an international consensus that most of these disparities are unjust and should not be tolerated.

For us as researchers, there is an urgent need for rigorously conducted primary research and systematic reviews that can guide decisions about how best to tackle inequities.

Winston Churchill has this to say on the need for equity:

"Disease must be attacked in the poorest or the richest in the same way as the fire brigade will give full assistance to the humble cottage as readily as to the most important mansion."

-Winston Churchill, 1946

Addressing the inequity problem is in our best interest. As Nils Daulaire of the Global Health Council points out:

"Health inequities lead to greater dangers for all. These inequities are often born out of injustice. We may never be able to eliminate injustice, but ... we can never simply accept it."

List of references may be requested by writing to the Editor at: inclen@inclentrust.org

Knowledge 'Plus' Program . . . (from page 3)

among countries in terms of equity and applicability; 3) equity issues involved; 4) within the interest of INCLLEN members; 5) feasibility; and 6) availability of evidence. Other members of Team A are Shally Awasthi (India), Antonio Dans, Manjula Datta (India), Prashant Joshi (India), Vic Neufeld (Canada) and Diana Pinto (Colombia). Srinath Reddy serves as consultant.

Team A has raised several key issues with regard to its work. For instance, it recommended that the persons who would develop the KP packages should include representatives from policy-making bodies, health care-related professions and academic institutions, and the users and target populations of the proposed interventions. Guidelines and attributes to identify clients and stakeholders have been formulated by the team. It also proposed several strategies on how future clients would be identified during the program's subsequent phases. Once implemented, the KP packages would be monitored and evaluated through process and health outcomes and other less "tangible" outcomes like changes in attitude-behavior and satisfaction of expectations of clients, users and target population. Ultimately, the KP packages are envisioned to include methods on how clients, or users, could select and incorporate valid relevant knowledge in their health care decision-making.

Team B has reviewed existing checklists, scales, and grading systems to develop its own tools for the KP packages. These include: 1) a "filter" or lens to appraise the validity of original studies; 2) a lens to appraise applicability of studies; 3) equity lenses that would evaluate studies both individually and as an input to the development of guidelines; and 4) a standard for Grades of Recommendation. Utilizing e-based strategies for consensus building, the Team has achieved 33 – 95% of the work required for the various lenses. Team

B members are: Jose Acuin and Leonila Dans (Philippines), Rodolfo Dennis (Colombia), Kang Deying (China) and Vivian Robinson (Canada). Peter Tugwell, Alex Jadad, Tessa Tan-Torres and Gordon Guyatt serve as consultants.

The ICT Team, or Team D, has already developed and tested a web-based software that stores details of a reference/citation in a database. The software, which comes with a search engine developed with the help of IT consultants in India, is capable of searching references by keyword, title, author and abstract. It can also do content-based search when a user is not familiar with the title or author of the article he/she is looking for. The program was developed with effective search algorithms that utilize less system resources and is able to display results in microseconds.

Team D has already tested the software for speed and efficiency by uploading 56,539 articles into the server. A typical search was requested and the results obtained in 0.71 seconds. It has been proposed that the functions of the search engine be broadened to incorporate the lenses for validity, applicability and equity being developed by Team B. In the future, the KPP website will have a KPP e-Group software that will make it possible for members to communicate, collaborate and share information any time and from anywhere in the world. The features of the KPP digital work space will include: discussion Board, document management, task scheduling, news, polls, photo, appointments, and member profile.

Team D members are: Shrikant Bangdiwala (USA), Cynthia Cordero (Philippines) and Sergio Munoz (Chile). Consultants are: Nancy Johnson, Adrean Yang and Arunachalam Rajagopal.

Juan Gabriel Ruiz, Antonio Dans, L. Jeyaseelan and Visanu Thamlikitkul, Knowledge "Plus" Program Team Leaders

New Publications

1. Lautenbach E. Fluoroquinolone utilization in the emergency departments of academic medical centers: Prevalence of, and risk factors for, inappropriate use. *Arch Intern Med* 2003;163: 601-5.
 2. Lautenbach E. Changes in the prevalence of vancomycin-resistant enterococci in response to antimicrobial formulary interventions: impact of progressive restrictions on use of vancomycin and third generation cephalosporins. *Clinical Infectious Diseases* 2003; 36: 440-6.
 3. Metlay J. Prior antimicrobial drug exposure: a risk factor for trimethoprim-sulfamethoxazole-resistant urinary tract infections. *Journal of Antimicrobial Chemotherapy* 2003; 51, 963-970
 4. Alves da Cunha AJ, Amaral J, Fontenele e Silva MA Inappropriate antibiotic prescription to children with acute respiratory infection in Brazil. *Indian Pediatrics* 2003;40:7-12
 5. Keerasuntonpong A, Thearawiboon W, Pnathawan A, Judaeng T, Kachintorn K, Jintanotaitvorn D, Suddhisanon L, Waitayapichet S, Tinangrim S, Thamlikitkul V. Incidence of urinary tract infections in patients with short-term indwelling urethral catheters: A comparison between a 3-day urinary drainage bag change and no change regimens. *Association for Professionals in Infection Control and Epidemiology, Inc.* 2003; Vol. 31 No.1:9-12.
 6. Bangdiwala S, de Paula C, Ramiro L, Munoz S. Coordination of international multicenter studies: Governance and administrative structure. *Salud Publica Mex* 2003; 45: 58-66
- Note: The English version of this paper is also available at: <http://www.insp.mx/salud/index.html>
7. Belfort MA, Anthony J, Saade G, Allen J, Festin MR, et al. A Comparison of Magnesium Sulfate and Nimodipine for the Prevention of Eclampsia. *The New England Journal of Medicine*. 2003; 348:304-11.
 8. Cuervo LG. Interventions for preventing or improving the outcome of delivery at or beyond term. *WHO Reproductive Health Library, No 6, Geneva, World Health Organization*.2003.
 9. Salim A, Rengifo-Pardo M, Vincent S, Cuervo-Amore LG. Melasma. *BMJ books, London*.2003.
 10. Festin M, Lumbiganon P, Tolosa J, Finney K, Ba-Thike K, Chipato T, Gait n H, Xu L, Limpongsanurak S, Mittal S, Peedicayil A, Pramono N, Purwar M, Shenoy S, Daly S. International survey on variations in practice of the management of the third stage of labour. *Bulletin of the World Health Organization* 2003;81:286-91
 11. Belizario V, Amarillo M, De Leon W, De los Reyes A, Bugayong M, Macutangay B. A comparison of the efficacy of single doses of Albendazole, Ivermectin and Diethylcarbamazine Alone or in Combinations Against *Ascaris* and *Trichuris spp*. *Bulletin of the World Health Organization* 2003:81:35-42
 12. Carr V, Neil A, Halpin S, Holmes S, Lewin T. Costs of schizophrenia and other psychoses in urban Australia: findings from the Low Prevalence (Psychotic) Disorders Study. *Australian and New Zealand Journal of Psychiatry* 2003; 37: 31-40.
 13. Neil AL, Lewin TJ, Carr VJ. Allocation of resources and psychosis. *Australian and New Zealand Journal of Psychiatry* 2003; 37: 15-23.

Equity and Clinical Epidemiology (from page17)

Agency (CIDA). Discussions are underway on how to apply this approach in other LMIC's for other types of decisions including the rational use of drugs in India, management of HIV/AIDS in Thailand, and tuberculosis management in South Africa.

Dr. Tugwell and Mark Petticrew are working on a Cochrane Collaboration Health Equity working group to devise methods for systematic reviews assessing whether interventions enhance health equity. This methods group will also advise the sister Collaboration, the Campbell Collaboration, which looks at the evidence of effects of legal, social, policy and educational interventions on health.

Other examples include the International Network for the Rational Use of Drugs (INRUD), geographic information systems (GIS) and mapping software such as CIETmap. A collaborative study of INCLLEN and University of Ottawa that looks at knowledge translation policies of funding agencies is described in a separate article (see page16).

Dr. Tugwell said that in the future, his group would investigate whether and how information technology has the potential to disseminate these promising tools for global use. Efforts are now increasing to test and evaluate information technology approaches for applying the approaches listed above. The challenge is to ensure that information technology tools consider their impact on health equity and work towards enhancing health equity.

These examples are the beginnings to answer the question: "What works to reduce inequities in health?" As Dr. Tugwell said, "The challenge for us all, is to continue building the evidence on what works to reduce inequities in health, and then ensure that these interventions are implemented in practice!"

Reference:

Gwatkin DR (2001). The need for equity-oriented health sector reforms. *Int J Epidemiol* 2001; 30: 720-3.

Announcements

New INCLEN Trust Board of Trustees and INCLEN, Inc. Board of Directors

A warm welcome to **Dr. Ranjit Roy Chaudhury**, Chair, Board of Directors, INCLEN Inc., and Chair Elect, INCLEN Trust. See *INCLEN News* January 2003 for his profile.

A warm welcome to **Dr. Demissie Habte**, new member of the INCLEN Board of Trustees. Dr. Habte is currently a Consultant Health Specialist of the Regional Human Development, African Technical Families at the World Bank in Washington, D.C. Previous to this position, he served as the Lead Health Specialist in the same World Bank program. He was formerly the Director of the International Centre for Diarrhoeal Disease Research in Bangladesh where he successfully raised big grants and endowments for the Centre. He also served as Dean of the Faculty of Medicine of the Addis Ababa Clinical Epidemiology Unit. He has more than 3 decades of experience and proven competence in clinical and academic pediatrics and child health; a demonstrated record of research accomplishments in health problems of children; and acknowledged skill in management and administration of both academic and research institutions. Dr. Habte also served as a member of the INCLEN, Inc. Board of Directors from 1997-1999.

A warm welcome also to **Dr. James Volmink**, who is the present chair of Primary Health Care (PHC) in the Faculty of Health Sciences of the University of Cape Town. He also served in various posts at the South African Cochrane Centre, Medical Research Council. In a career that spans over two decades, he has served in various academic and research institutions, advisory boards, committees, and task forces both internationally and in South Africa. Dr. Volmink joined the INCLEN Trust Board of Trustees and the INCLEN, Inc. Board of Directors effective January 1, 2003.

Warm felicitations to **Dr. Palitha Abeykoon**, another new member of the INCLEN, Inc. Board of Directors effective January 1, 2003. Dr. Abeykoon served four years as Director of the Department of Health Technology and Pharmaceuticals, WHO South East Asia Regional Office, New Delhi, India. His career in WHO has spanned over a decade, having held posts that include assignments in Nepal and Indonesia. He also received numerous awards from Sri Lanka, India, Australia, New Zealand and the USA for his outstanding contributions to medical education. Dr. Abeykoon is currently based in his home country, Sri Lanka.

- The LatinCLEN Board of Directors elected the new Executive Committee (EC) for the period 2003-2005. **Dr. Juan Manuel Lozano** took over from **Dr. Sergio Muñoz** as the LatinCLEN President. The latter continues to serve as EC member. **Dr. Antonio da Cunha** was elected Vice-President, and Drs. Enrique Rendon and Myriam Orsotegui as EC members.
- Congratulations to **Dr. Jeyaseelan** for being recently elected as the new Secretary of IndiaCLEN. Dr. Jeyaseelan can be reached at ljey@hotmail.com
- **Dr. K.T. Shenoy** has taken over from **Dr. M. Narendranathan** as the new Director of the CERTC at the Medical College of Trivandrum. Dr. Shenoy can be reached at ktshenoy@md3.vsnl.net.in
- **Dr. Pisake Lumbiganon** is the new CEU Director of Khon Kaen succeeding **Dr. Sumitr Sutra**. As Khon Kaen CEU Director, Dr. Lumbiganon will also be the Thai-CERTC Co-Director together with the directors of Mahidol and Chulalongkorn CEUs. He can be reached at pisake@kku.ac.th
- **Dr. Kingkaew Pajaree** replaced **Dr. Siriporn Pitimana-aree** as Head of the Thai-CERTC Secretariat. Dr. Pajaree can be contacted at kkpy_2000@yahoo.com

News on CEUs, CERTCs and CLENs

- Congratulations and best wishes to **Dr. Maria del Pilar Navia** for assuming the post as CEU Director of the Universidad Mayor De San Andres (UMSA). She can be reached at pilarnavia@mail.megalink.com
- **Dr. James Njogu Kiarie** assumes the post of Director of the Clinical Epidemiology Unit of the University of Nairobi on May 30, 2003. He took over from **Dr. Erastus K. Njeru**. **Dr. Vincent Muoki Mutiso** is the deputy director of the CEU. Dr. Kiarie's email address is: jkiarie@swiftkenya.com
- **Dr. Teraporn Vutyavanich** has taken over from **Dr. Anon Manmontri** as CEU Director of Chiang Mai University in Thailand. The CEU also has a new Sponsor, **Dr. Supot Wudhikarn**, Dean of the Faculty of Medicine of the University. For inquiries, Dr. Vutyavanich can be reached at tvutyava@mail.med.cmu.ac.th or at kkanjana@med.cmu.ac.th
- The entire INCLEN family welcomes **Tohoku University School of Medicine** as a second CEU in Japan. The CEU director is Dr. Naruo Uehara, with the ff. coordinates: email naruo@13.rim.or.jp and address: Tohoku University School of Medicine, 2-1 Seiryomachi, Aoba-ku, Sendai City, JAPAN
- Warmest congratulations to the **Clinical Research Centre of the Hospital Kuala Lumpur** for being accepted as an INCLEN CEU. The Centre, represented by its Director, Dr.

Conferences

- **The 5th International Conference on the Scientific Basis of Health Services** will be held on **September 20-23, 2003** at the **Capital Hilton in Washington D. C.** With the conference theme, “*Global Evidence for Local Decisions*”, the series of meetings aims to improve research dissemination, synthesis, translation, and uptake at different levels of decision making in health services. With more than 26 collaborating organizations, including INCLLEN, the conference is a global marketplace of ideas and potential collaborations. Co-hosted by the Academy of Health Services Research and Health Policy and the Agency for Healthcare Research and Quality (AHRQ), this year’s conference is organized around these themes: National Strategies for Organizing Health Services Research, Using Evidence to Improve Clinical Practice, Using Evidence to Improve Health Services Management, Using Evidence to Improve Policymaking, Using Evidence to Alleviate the Burden of Specific Diseases (mental health, cancer, cardiovascular, maternal and child health, and HIV-AIDS). For details and other additional information on the conference, visit www.icsbhs.org

Lim Teck Onn, has been an active member of INCLLEN-Southeast Asia since November 2001. For more information about the Centre, visit www.crc.gov.my

Warmest felicitations to the following new CEUs in Barcelona, Spain:

- **Hospital de la Sant Creu i Sant Pau Iberoamerican Cochrane Centre.** The CEU Director, Dr. Xavier Bonfill, and Sponsor, Dr. Joaquin Esperalba, can be reached at xbonfill@hsp.santpau.es or cochrane@cochrane.es. More information about the Centre can be found at this website: www.cochrane.es
- **Assessment, Prevention and Support Unit (UASP)** of the University of Barcelona School of Medicine. UASP Director and Sponsor, Dr. Antonio Trilla and Dr. Ma. Teresa Estrach, respectively, can be reached at ATRILLA@clinic.ub.es or at this postal address: University of Barcelona School of Medicine, Villarroel 170, E-08036 Barcelona, Spain.

IEO Staff

Ms. Lucie C. Valdez, from Manila, Philippines joined the INCLLEN Executive Office as Administrative Assistant last May 1, 2003. She can be contacted at lvaldez@inclentrust.org **Ms. Ciela Sarmiento**, previous administrative assistant, joined a non-government organization for sustainable development.

- **The Global Forum for Health Research (GFHR)** announces new dates for its 2003 annual meeting. **Forum 7** will be held on **December 2-5 2003** in **Geneva, Switzerland**. The annual Forum is an international meeting bringing together around 700 participants from governments, multilateral organizations, bilateral aid donors, international foundations, national and international NGOs, women’s organizations, research institutions and the private sector. It offers the opportunity to present work in progress, recent results or new work, to continue the analysis and debate and to measure progress on the road to correcting 10/90 gap in health research. For details: contact Louis Currat, GFHR *Executive Secretary* or visit the website at www.globalforumhealth.org
- **The Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET)** announces new dates for this year’s **Southeast Asian and Western Pacific Bi-Regional TEPHINET Conference**. This will be on November 24-28, 2003 at the Club Panoly Resort, Boracay, Philippines. The theme is “Collaboration for Effective Public Health Surveillance and Response”. More information on the conference is available at <http://geocities.com/tephinet2003> or you can email inquiries to: tephinet2003@yahoo.com
- **The International Society for Pharmacoeconomics and Outcomes Research (ISPOR)** announces its two upcoming international conferences:
 - **The First ISPOR Asia Pacific Conference** is scheduled on **September 1-3, 2003** at the **International Conference Center and Portopia Hotel, Kobe Japan**. Early registration deadline is on August 1, 2003.
 - **The ISPOR 6th Annual European Congress** is scheduled on **November 9-11, 2003** at **Princesa Sofia Intercontinental in Barcelona, Spain**. This year’s theme is “Outcomes Research: Bridging the Gap Between Policy and Research”. Deadline for early registration is on October 6, 2003.

Contact info@ispor.org or visit their website at www.ispor.org for more details.

IMPORTANT REMINDER:

Submit your INCLLEN Global Meeting XX abstracts on or before 15 September 2003.

Go to www.inclentrust.org for details.

INCLIN Trust Clinical Epidemiology Units (CEUs) and Clinical Epidemiology Resource and Training Centers (CERTCs)



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