Research for change

Just listen: research and activism can walk hand-in-hand

The goal of Health for All is underpinned by health systems research, but the subject is still ignored, says Ravi Narayan

Ravi Narayan leading the People’s Health March at the Second People’s Health Assembly at Cuenca, Ecuador, 22 July 2005 – carrying the banner of the local Ecuadorian National Health Committee.

Completing his three-year term as co-ordinator of the Global Secretariat of the People’s Health Movement – before it moves to the Middle East – activist researcher Ravi Narayan, a member of the Foundation Council of the Global Forum, speaks of the necessity for all groups working towards people’s health, including researchers, to listen to each other.

Ravi Narayan

In the 1980’s, after WHO’s 1978 declaration of Health for All by the Year 2000 at Alma Ata, many people were working for Health for All; but NGOs, government, and researchers were all boxed up in their own little worlds, not talking to each other, not affecting each other.

So four or five of us in Bangalore, India, started the Community Health Cell (CHC) – now the functional unit of the Society for Community Health Awareness, Research and Action.

It’s a multidisciplinary group of professionals, based initially in Bangalore, but now in many parts of India. We all helped to build an interface between these three groups – NGOs, government and researchers – and amongst other things we built a People’s Oriented Health Movement in India.

Some of my colleagues and I were very deeply involved in the first international People’s Health Assembly in Bangladesh in 2000, and I was invited to continue to build such coalition in other places since 2003. That explains to some extent even my role now on the Foundation Council of the Global Forum for Health Research: my concern is to build linkages and dialogue.

› RHN: You were also Professor of Community Medicine in Bangalore, and an Overseas Lecturer for the London School of Hygiene and Tropical Medicine. What research did you pursue?

RN: Well I was very involved with some pre-Alma Ata primary health care strategies – health cooperatives – and also in the tea plantation communities of South India. There we evolved something called the comprehensive labour welfare scheme.

These experiences and ideas contributed to primary health care thinking, and made the Indian Government very enthusiastic about being a signatory of the global Alma Ata Declaration when it came about in 1978. We had started all these in 1974, so we felt very endorsed by the Alma Ata declaration itself.

› RHN: So these were effectively action research projects, were they?

RN: Yes, this was action research. We ran India’s first health cooperative – which was when we transplanted a health function to a milk cooperative in rural India, in Karnataka. The Indian Council of Medical Research selected it as one of the 14 alternative approaches to health care in 1976.

The second thing that I did was to set up a small occupational health unit, which focussed on agriculture. I did a very large study on tea plantation workers in South India, looking at potential occupational hazards. It was probably one of the largest studies on agricultural communities in the world.

Tea plantations are geographically well defined, so one can study health system development and epidemiological needs in a closed community.

So they’re ideal for research; but they’re also very useful and constructive, because you’re dealing with the plantation management – and by giving them evidence of what is happening you can try and build health systems that are
more responsive to the needs of planta-
tion labour.

At CHC we also researched TB in a very
disadvantaged part of our state, looking
at the social determinants and the
health system issues that were making
the TB programme unsuccessful.

The world was then moving to the
new approach called DOTS – directly
observed treatment, short-course. But
in the social milieu of India, particularly
in the disadvantaged rural areas, with
our health systems being as they are,
we felt DOTS would not be adequate.
It was too biomedical and techno-man-
gerial.

Our study was done by Thelma Narayan,
presently the Coordinator of the CHC,
and presented at the Global Forum for
Health Research in Tanzania in 2002,
where we showed a whole range of
social, economic, cultural and political
factors that determine the success of
the TB programme. And we felt that if
biomedical researchers don’t look at
health system issues and social determi-
nants, TB programmes would not really
get far.

We’re quite thrilled with the fact
that health systems research has now
became a very important theme of the
WHO – and I was honoured to be a
member of its Task Force on the topic.
We felt that in recent years some of the
early research that we’d done, which
was considered in a way marginal to
mainstream health research had now become
mainstream.

Now health systems research and social
determinants research are well recog-
nized – and now we have a whole
WHO Commission on Social Determin-
nants which many of us are also
working closely.

The CHC basically focused on public
health challenges and their social deter-
minants and the health systems needed
to address them. So you can understand
why we are so thrilled with what’s now
happening at an international level –
and as a Global Forum Foundation
Council member and in other capaci-
ties, I will try and push for health sys-
tems research and social determinants
research in all health programmes.

> RHN: Your research seems closely
connected with pressure for change.

RN: I am an activist researcher. I am
concerned about two global trends
which I feel at present seem counter to
the whole issue of looking at social
determinants and health systems and I
hope the Global Forum in Cairo in Octo-
ber will help to shift the balance a bit.

One is that donor funds still look at TB,
malaria and HIV/AIDS as single vertical
disease programmes. And no doubt they
are very important diseases but if you go
a little behind them, all three of them,
you find health system issues and social
determinants, which are cross cutting.

So whether you talk about development
strategies or equity, gender, stigma or
poverty or whatever, they affect all
three and it’s important for the donors
also to allow for projects that look at
cross cutting, health system and social
determinant themes rather than individ-
ual disease or health problems.

We hope that the WHO Commission on
Social Determinants of Health will make
a breakthrough on that.

The second trend is that there are
groups like Gates Foundation who still
are looking for drugs and vaccines – and
we’ve been trying to suggest that
existing drugs and vaccines that we
have, and good ones at that, don’t
reach the people they are supposed to
reach. And so there’s absolutely no
guarantee that you will be able to
reach them with the new ones unless
some of the funds, 10% maybe of the
money, spent on research, is also be
spent on finding why existing drugs
and vaccines don’t reach the people.

> RHN: Right, I understood. But let me
be devil’s advocate. Isn’t the principal
factor in this failure to reach the
needy really political and economic?
It’s not so much to be challenged by
research, as to be challenged by polit-
ical and community action.

Speaking at the welcome ceremony to the
People’s Health Movement in Canar, Ecuador,
before the Second People’s Health Assembly.

RN: Well, I think that’s only partly true
and I tell you why I say that. We need to
look at social, economic, political and
cultural determinants also as research-
able evidence, not just as ideological
positions...

> RHN: I see, that is the point.

RN: There is a reason for that. There is
increasing evidence all over the world in
a lot of research, which is at present is
not mainstream, but marginal, some of
it from respected academia, not all from
People’s Movements and Civil Society
campaigns, that the existing vertical top
down single disease strategies don’t
work.

And they don’t work because these
larger determinants have not been
looked at adequately. And even groups
like World Bank regularly generate data
on these issues but sometimes tend not
to use them.

For example, the World Bank has
enough data to show that user fees
don’t work anywhere, if you use access
for poor people as an indicator. It’s
maybe very good for a health system to
generate some funds but if you use that
as an obstacle for poor people to access
whatever you want to distribute or pro-
vide, it’s definitely not a good idea.

So what would we call this? Economic
evidence or an ideological position? I
feel researchers must look at all the data
and use the Cochrane Foundation type
of approach asking, is there really evi-
dence? [See “South African Cochrane
Centre”, this issue pp 28-9].

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> Everybody is also pushing public-private partnerships. There is no evidence that public private partnerships support primary health care or public health goals. So why are we pushing a major policy shift in this direction? Where are public health programmes or primary health care programmes which are public-private partnerships, and which are working towards the Health For All goals? Because when you get private sector coming in with a profit motive, it will shift priorities.

I feel in some of the new official roles I’m going to play, in the Global Forum Foundation Council, the Public Health Foundation of India, and on the Editorial Board of the British Medical Journal, I’ll be able to provide or locate this sort of evidence – and to use hard evidence to challenge the system. So it’s not only the strength of people on the streets, or people demanding health for all as a right – but evidence that is also today on our side.

> RHN: That’s the point you were making at the Global Forum in Mumbai in 2005 and I was very struck by that. But what do you mean by saying that this research is somehow not mainstream? Where is it being published?

RN: Well, it is being published, as reports by organisations, or in journals, but only on the sidelines. Let me give you one example. Some years ago I was asked by the Karnataka government, because they set up a health task force in the state, to look at externally funded projects. I looked at a combination of about 12 externally funded health projects. Karnataka, as you know, has a 55 million population, about the same as the UK.

There were World Bank, DFID and UNICEF programmes in TB, malaria and other diseases. The study looked at what these externally funded projects did to government health systems. We asked, through a participatory, interactive process: what do they do to sustainability and integration? Two very important issues.

My study showed that vertical programmes, when you have twelve like that coming to a state with each funding agency negotiating with the state with its own evaluation procedures, and its own schedules, the health system gets disintegrated. So most of it is unsustainable, because there are twelve systems rather than one integrated system.

Now this was reported and it helped Karnataka government make a decision. The 2001 WHO Commission on Macroeconomics and Health, chaired by Jeffrey Sachs, had a group, which looked at international funding, and they know about my study. It is included in the references – but unfortunately they didn’t take the recommendations seriously, just mention it in the reading list. If they’d actually gone into that data they wouldn’t have made some of the recommendations they did. But groups like the Global Forum for Health Research, by facilitating researchers with such data available in the annual Forums, will slowly begin to change the balance.

> RHN: So there may be two issues there. One may be that there’s not a critical mass, as such, of research and another might be that it’s being ignored for ideological reasons?

RN: Yes – I think they both are important. One is that most of the money is getting more and more linked to industry, and industry wants products, they don’t want processes – which they cannot own at some time and sell in some way. Now I understand that that’s the way drugs and vaccines will develop. But if you say after studying non-communicable disease, that what you have to now do is to change people’s lifestyles, you can’t sell that easily. At the most you can produce a little manual on healthy living or something.

But commercially that’s a bit limited, whereas if you say that you take this pill and your stress will come down, that’s something you can sell.

So part of what you just asked was a clue, that research in those fields is not adequately funded because a lot of our funding is now coming from industry and we don’t have independent research from government bodies and from other networks that will look at health systems and social determinants. There’s no money in that.

Another problem is that a lot of researchers who understand health systems often also do a lot of single disease type of research – because that’s the way they can get some funds. And then they go to meetings, which are also single disease oriented.

So nobody is discussing health systems! Whereas if you actually went and listened to a conference on malaria and a conference on immunisation and a conference on TB, you find all of them are saying ‘we are not able to transfer our ideas into the field because of health system issues, social determinants’. But then they won’t research it! RW