› 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

SUMMARY

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.

**› RHN: Can you first tell us a little of your background?**

**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 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.


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.

**› 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 plantation 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-managerial.

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 determinants, 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 research had now become mainstream.

Now health systems research and social determinants research are well recognized – and now we have a whole WHO Commission on Social Determinants with which many of us are also working closely.

The CHC basically focused on public health challenges and their social determinants 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 capacities, I will try and push for health systems 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 October 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 individual 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 political 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 researchable 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 provide, 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 evidence? [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 than 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

**I'll use hard evidence to challenge the system – so it's not only the strength of people on the streets.**

**RAVI NARAYAN**

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** ■

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www.globalforumhealth.org/realhealthnews/RealHealth.php

**People's Health Movement**
**www.phmovement.org/**

**Alma Ata Conference on Primary Health Care, 1978: Declaration on achieving 'health for all by the year 2000'**
www.euro.who.int/AboutWHO/Policy/20010827_1

**The Community Health Cell**
www.sochara.org/about_us/overview.htm

**WHO Alliance for Health Policy and Systems Research**
www.who.int/rpc/alliance/en/

**WHO Commission on Social Determinants of Health**
www.who.int/social_determinants/en/

**WHO Commission on Macroeconomics and Health**
www3.who.int/whosis/menu.cfm?path=whosis,cmh&language=english