Reflections on International Health Research

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In the summer of 2003, we attended the bi-annual conference of the International Society for Equity in Health (ISEqH) held at the University of Toronto. We were interested in learning more about international health research because we felt that although we had some background in core health research, we hoped to see how such knowledge was applied on a global scale. We had previously learned about the gap that exists in health research where 90% of health research funding goes towards diseases that affect only 10% of the world's population. This shocked us and we wanted to learn how the leading researchers in the international health field were addressing this problem. We went into the conference optimistic that significant changes were occurring and that we could be witness to them. However, we came out confronted by the reality that such changes were slow and riddled with difficulties.

ISEqH was founded to "promote equity in health and health services internationally through education, research, publication, communication and charitable support." The conference opened with a presentation by native drummers, a reminder of the disparities that exist in health care even within our own country. The health status of Aboriginals in Canada is generally comparable to that of developing countries, largely due to inadequate quality of and access to health care.

The weekend was filled with workshops and presentations by health researchers from around the world. One of the most memorable workshops for us was "A Report Card on G8. Health and Development Commitments and the New Plan for African Development (NEPAD)". This workshop on African Health and Development examined past commitments of the Group of 8 (G8) countries to improve development and health research. Moreover, they discussed the impending G8 summit in Kananaskis and its focus on African health and development as outlined in NEPAD. This was a plan made by Africans for Africans to gain economic stability and independence. One topic discussed in the workshop was the brain drain from African countries to G8 nations. For instance, the USA saved an estimated US $26 billion in training costs because of the

130,000 foreign physicians practicing in the US. Africa loses approximately US $4 billion per annum through migration of top professionals (not only health professionals). Although NEPAD made recommendations to reverse this process, the speakers criticized it for its lack of detail and direction. Consequently, the speakers made alternative recommendations by calling upon the G8 nations to acknowledge the economic benefits they reap from migration of health professionals. Furthermore, they suggest that the G8 reimburse developing countries' investments in the production of health professionals. Participating in this workshop exposed us to the hardships that Africa faces and the lack of past commitment by the G8 countries to provide assistance. It was interesting to see the dynamic and solidarity between Western and African health researchers in their commitment to improving the health in African nations.

Many of the presentations were based on public health research studies, such as "Hospitalization and recent immigration in Toronto, Canada." It was interesting for us to see the application of epidemiological concepts we had learned in many Health Sciences classes. In particular the socio-economic determinants of health were emphasized in many of the presentations. At the time, we had not taken Health Interventions, but it would have been interesting to apply the skills from that course to critique the studies presented at the conference. Looking back, it is possible that any flaws in these studies were due to the political, economic, or social climates of the countries that they come from. For example, civil wars or military dictatorships may restrict access to certain populations or limit funding for research. We feel that it is important to further examine the context in which these studies were completed to gain a greater understanding of the health issues in question.

Although the emphasis of the conference was on health research, we witnessed a heated discussion regarding the role of health researchers in advocacy.

It was clear that two camps existed: one that was passionate about advocating through their research and another that saw the two as separate arenas. Even within the organization's name itself, the International Society for Equity in Health, the word 'for' implies an advocacy component. However, some members shied away from advocacy for fear of undermining the legitimacy and impartiality of their research. Researchers who advocated for policy change felt that they were responsible for exercising their ability to influence policy. We feel that suggestions such as creating a coalition for global health research would be a good starting point in establishing a relationship between the research and advocacy communities. This debate brought to our attention an example of issues that we, as potential health researchers, will have to confront in the future. Moreover, it was refreshing to see research in a real world context and the power that it has to create change.

If these issues interest you, we strongly recommend conferences of this nature. They offer an excellent opportunity to apply your knowledge, to see different types of health research and to make interesting contacts. For more information on global health research, check out these links. M

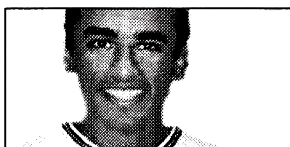
International Society for Equity in Health
www.iseqh.org

International Development Research Centre
www.idrc.ca

Canadian Society for International Health
www.csih.org

Health Care in Uttaranchal

The Far Side of the World



Abhishek Raut

On the first week of May 2003, twelve McMaster students representing Student International Health Initiative travelled across the globe to a newly created and very rural region of Northern India known as Uttaranchal. Their goals were to research and understand all aspects of health that they encountered. Of the twelve students, Asad Moten, Abhishek Raut, and Jerome Waidyaratne decided to investigate the accessibility of health care to the rural populace of Uttaranchal. This is an adaptation of their report.

A Background into Uttaranchal

It is of no wonder why Uttaranchal is natively known as "Dev Bhoomi" - a phrase which translates from Hindi to "Abode of the Gods". The state of Uttaranchal is surrounded by unparallel natural beauty, almost untouched by urbanism. But it is this very splendor, which contributes to its dilemmas of health care. Populations are scattered with an average of 159 persons/square km spread out in a handful of cities and 16,414 villages - each with average populations of 100.

The primary communicable diseases in the region of Uttaranchal include tuberculosis, malaria, and leprosy, with TB being higher than the national average. Non-communicable diseases are also very prevalent. Approximately 46% of the population suffer from some degree of anemia, while 4% suffer from iodine deficiency. Malnutrition also plagues many, particularly women and children, causing greater vulnerability to disease and is thus strongly linked to the prevalence of the communicable diseases.

The Problem

The greatest issue that Uttaranchal faces today is its isolated population leading to a lack of resources to properly network healthcare with those who require it. Throughout all of our conversations with villagers, doctors, and workers, the most important recurring theme seemed to be infrastructure: roads, electricity, and location. We asked many of the people we spoke with what changes they would bring about if they were in a position of power, and the responses were all quite similar. A villager summed it up by saying "If I were made Chief Minister of the state, I would first build a roadway to my village and secondly provide lights and electricity." The majority of people who shared this response felt that better health care would come naturally if the infrastructure were improved. The location of health facilities as observed by us seemed to be a limiting factor in the quality of health care. For instance, a villager who fell sick in a remote village in that region would first have to go to Quansi (the nearest