Summary of the Health Transition Workshop at Harvard University

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This workshop was the third of a series on the health transition sponsored by the Rockefeller Foundation. The first, in Canberra, addressed the question: ‘What is the health transition?’ The second, in London, asked: ‘How does one go about studying the health transition?’ This third and final workshop posed the challenge: ‘How does social science research relate to health policy and action?’.

The workshop was organized into three parts. On the first day, we reviewed the fields of health behaviour, politics, economics and health-care systems. Four case studies were discussed on the second day. The cases focused on diseases particular to developing countries, malaria in the Amazon and diarrhoea in Peru; and health problems common to developing and industrialized countries: AIDS and smoking. Additional attractions were the first day’s dinner speech by William Foege on the necessity of social research for social action, and the spontaneous and candid after-dinner exchange on the second day, which centred on issues of North-South relations. Also noteworthy was the reaffirmation of the fundamental importance of research capacity building within developing countries.

The highlight of the event, in my opinion, was the concluding sessions on the third day. The morning panellists succeeded in synthesizing the earlier sessions by integrating research areas and specific problems, basing their assessments on their own rich and diverse experiences. Just before the final session, smaller working groups formulated specific recommendations directed to three audiences: national governments, international agencies, and development (non-governmental) action projects.

This summary is divided into four parts. It begins with a preliminary review of several unresolved challenges raised by participants, then addresses, in turn, three basic questions: is the health transition concept useful? What are the linkages between social research and social action? And how can an evolving Health Transition program make a difference?

Unresolved challenges

Nirmala Murthy posed the first challenge when she observed ‘Patients need doctors, but who needs a social scientist?’ The question is simple; yet it effectively sums up the major challenge to which the health transition program must respond. One possible response is that as long as medical practice deals with the care of individuals, the social sciences are needed by populations, communities, and other groups. For many, if not most, of the major determinants of health cannot be addressed by individually-oriented medicine. Health equity, for example, entails the distribution of resources among individuals in populations. Health promotion and prevention, as noted in this workshop, are very much socially-conditioned phenomena. Even most health-care policies and programs depend upon population-based approaches.
A second challenge came from Achola Pala Okeyo: ‘How does social science make a difference in the everyday lives of people living in a community?’. Unlike the natural sciences, the social sciences do not produce ‘magic-bullet’ technologies that immediately solve practical problems. Rather, as David Mechanic reminded us, the social sciences deal with extremely complex behavioural and social systems that can only change slowly. While resistant to change, these human systems are also extremely powerful and undoubtedly have profound health implications.

On the last night, Elias Sevilla Casas diplomatically offered the third challenge. Recounting the process by which a major international funding agency was asked to leave Colombian universities in 1975, he concluded with the following central concern: ‘Given an understanding of changing contexts and a willingness to learn from experience, how can a new program, such as the health transition program, create a new relationship with that agency?’. The careful crafting of collaboration and communication patterns, together with the development of shared values and commitment, is required.

**Significance and usefulness of the health transition concept**

The timeliness and significance of the health transition concept was reaffirmed by all participants. David Mechanic argued for the importance of ‘psychological modernity’ in influencing health attitudes, behaviour, and outcomes in industrialized countries. Stephen Weiss reviewed the contribution of multidisciplinary behavioural approaches to health promotion. Arthur Kleinman argued that health behaviour is a powerful mediator of health outcome, and that research is needed to document the prevalence of neglected behavioural pathologies, e.g., alcohol and drug abuse, mental illness, and other disabling conditions.

In the discussions, Bonnie Stanton and Claudio Lanata reminded us of the importance of household health behaviour. The violence and neglect that are so pervasive in industrialized countries, and that are also being recognized in some developing countries (e.g., child neglect in Bangladesh and Peru), are examples of this. It was argued, moreover, that a behavioural focus should not be limited to populations at risk for illness. The attitudes and behaviours of those who control resources (policy-makers, academics, donors) also have important health consequences.

In the political economy session, Michael Reich examined the concept of ‘political commitment’ and challenged us to reflect upon the fact that some benefit, while others suffer, from any given health policy. The significance of political and social processes in shaping health policies was vividly illustrated by Daniel Fox’s case study of AIDS in three industrialized countries, where differing contexts have resulted in varying responses to the epidemic. James Rule noted that the health field, unlike others, has traditionally been cloaked in harmony. After all, preventing and curing illness is a value shared by all. Yet this apparent harmony may also mask a reluctance to confront the ‘conflictual’ aspects of health, which reflect the distribution of power and resources in society.

A missing link, Nancy Birdsall reminded us, is the absence of scientific work in health economics. Whatever else may be considered important in health, the reality is that in most societies, decisions about the allocation of resources are made by political leaders, who are guided by economic considerations. More research and more communication between economists and health scientists are needed.

Dr. Kiwara noted that many developing countries refuse to accept the present reality of having to cope with daunting health threats with far more limited economic resources than industrialized countries possess. He argued that international indebtedness and slow economic growth in developing countries, due in part to an an unjust international economic system, powerfully constrains health advances in many parts of the world.

Policies and programs in the health sector are the most direct response to preventable illness and premature death, and information and participation are central to the success of health interventions. A
report of an innovative project designed to combat diarrhoeal disease in Peru, presented by Drs. Lanata and De Romana, illustrated the importance of information, evaluation and mothers’ participation in efforts to implement a dietary management program. The involvement of health workers was shown to be crucial to the success of a survey of immunization coverage in a second paper by these authors.

Donald and Diana Sawyer examined the resurgence of malaria in the Amazon, noting that the social sciences are playing an important role in advancing the understanding of disease ecology and transmission that is essential for disease control. Burton Singer, in commenting on the malaria case, noted that high-technology approaches have all-too-often been inappropriately transferred from industrialized to developing countries. Mass insecticide spraying to combat the malaria vector and chemoprophylaxis directed against the parasite have clearly failed to control the disease. Social science research is needed to develop and promote strategies which are both medically effective and ecologically sound.

Often, the significance of social science research for the health transition was debated. The discussion focused on the search for a definition of social research in health and the identification of a research agenda. Some of the comments even implied that the concept of health itself should be redefined. The argument here is that enormous growth in health promotion activities and changes in health behaviour in industrialized countries have altered the traditional concept of health as a product of curative medical practice. Illness is no longer visualized as a haphazard event, but rather a consequence of lifestyle. In developing countries, health has become inextricably linked to overall development, perceived as both determinant and outcome of the pattern and direction of socio-economic change. Health and development, not just medicine, is emerging as an integrated and viable concept which is relevant to both industrialized and developing countries.

Research itself was also redefined, albeit inconclusively, in the course of the workshop discussions. W. Henry Mosley advanced the proposition that social science research was not simply the familiar hypothesis formulation and testing. Rather, he argued, research includes action. Social research, in Mosley’s view, includes the active participation of researchers in intervention; taking risks, dealing with mistakes and errors and learning from doing.

Yet another challenge was posed in the question: who sets the research agenda? Is it academics? Policy-makers? Donors? Perhaps not surprisingly, consensus did not emerge from the debate on this issue. What was clear, however, was that the customary notion of academics being supported by donors to produce research for use by policy-makers was naive and simplistic. Indeed, the issue of agenda-setting emerged as central to our next major theme.

**Social research and social action**

Examing the linkages between social science research and social action requires that the concept of research be more precisely defined. Research can refer to a product or to the process of generating that product. Kenneth Prewitt, for example, challenged the participants to identify key research findings, or ‘product’, that could make a health difference. Other participants, in contrast, focused on the processes involved in research production and use. The ‘product versus process’ debate was not resolved, but there was agreement that the participation of all relevant actors was essential to both.

In moving research into the public discourse and translating research results into public policy, a major challenge (from a scientist’s viewpoint) is how to generate demand for research findings from policy-makers. Our understanding of this process is minimal. W. Henry Mosley observed that policy-makers have answers for the problems they face; they are not looking for questions or hypotheses. Dr. Lanata recounted his frustration in dealings with health policy-makers in Peru.
One simple strategy might be to involve policy-makers in the formulation of the research agenda. However, Richard Cash argued that this could lead to the subordination of research plans to political bureaucratic goals, thereby compromising independence, creativity, and productivity.

One of the most valuable roles the social sciences can play, it was pointed out, is that of critic: raising questions, challenging established authority, and ensuring openness in assessing government performance. Nowhere is this role more poignantly visible than in the recent decimation of the intellectual community in China, where social criticism has provoked such violent responses from authoritarian rule.

Two general theories specifying the relationship of research to action were succinctly presented by Michael Reich. In the first, a particular research product is viewed as directly linked to the specific action decision. For an example of this direct linkage, we may look to the consistently successful use private business has made of social science. Demographic studies identify market segments, economic research pinpoints effective demand, and marketing departments invest in mass media campaigns in the hope of influencing consumer attitudes and behaviour. The success of the tobacco industry in propagating smoking, first in industrialized countries, and now, increasingly, in the developing world, reveals the power of social science research in the service of business interests. In fact, there emerged from the discussion a call for the application of social sciences to health promotion as a public good, a way of counterbalancing its use for purely commercial purposes. The question may be less whether social science is useful, than how to use this clearly effective tool to achieve social goals.

The second theory posits an indirect relation of research to action, in which movement from the former to the latter is mediated by some intervening factor. For David Mechanic, this mediating influence was ‘social climate’, or ‘a culture of ideas, attitudes, and activities’, which shapes the transformation of research results into pragmatic form. On another level, W. Henry Mosley’s paper shows us that certain types of intermediary organizations, themselves neither purely research, nor exclusively policy-oriented, can play a similar mediating role.

In the United States, we can point to certain ‘socially conscious’ advocacy groups: the Sierra Club, the American Cancer Society, the Natural Resource Defense Fund, which have assumed responsibility for mobilizing research results and other information in the public service. Allan Brandt’s exposition of the history of tobacco policy in the U.S. vividly underscores the powerful role of the American Cancer Society in forcing escalation of the exercise of public policy from simple letters to medical journals to a three-hour television show which beamed the Surgeon General himself into American homes.

Does this U.S. model of intermediary organizations have parallels in diverse developing countries? The United States is a pluralistic society with large private sectors, commercial and non-profit. Institutional forms in much of the developing world, in contrast, are young and fragile. In many countries, recent independence from colonialism has understandably resulted in efforts to strengthen national governments in newly sovereign states. The public sector controlled by the nation state dominates the institutional landscape.

Some exceptions to this pattern exist, and should be noted. India, for example, has many scientifically based advocacy groups: the Voluntary Health Association of India, the Nutrition Foundation of India, the Centre for Science and the Environment. There was a suggestion from Dr. Kiwara that perhaps ‘inappropriate’ exports from industrialized to developing countries (e.g. high-technology disease control strategies) should be abandoned in favour of the transfer of socially-oriented scientific advocacy groups. Indeed, it was noted that several American Washington-based organizations are providing methodological training for their counterparts in developing countries. These include the Children’s Defense Fund and many environmental lobby groups.
A third intervening factor is people, leaders and non-leaders alike. Elias Sevilla Casas noted that the University of the Andes has a virtual direct channel into the Ministry of Finance in Colombia, due to the movement of people between the university and the government. In Nigeria, contemporary leadership for primary health care is coming from a minister, Dr. Ransome-Kuti, who previously was a professor of paediatrics. During his university tenure, Dr. Ransome-Kuti undertook an experimental community-based health-care program. The lessons learned were implemented not through journal articles, but through the leadership of an engaged and committed scientist who moved from an academic setting into government.

It was pointed out, however, that people who are not in leadership positions also have an important role to play. Gelia Castillo urged that we should focus on the young. In contrast to established scientists, postdoctoral fellows, for example, are less indoctrinated, more willing to go to rural areas, more able to take risks and tolerate mistakes, and less worried about tarnishing their reputations. Young scholars are more likely to listen to people who suffer from, or are at high risk for, poor health. They have a better chance of generating new and creative ideas.

The importance of an ‘enabling environment’, to facilitate both types of research-to-action links was also discussed. The legitimization of the social sciences as an appropriate tool for addressing health problems was seen as possibly the most important enabling factor. Neither the powerful medical profession nor social scientists themselves at present view health as suitable subject matter for social research. But whatever the intervening factor, the linkage process, we must attract outstanding social scientists to health research, change perceptions of the roles and responsibilities of the various sciences, and provide peer support and professional recognition for social scientists as an incentive to become involved.

The discussion of social research and social action ended with a penetrating observation by Nirmala Murthy, who noted that fundamentally, social scientists and policy-makers belong to two distinct cultures. Murthy argued that we cannot assume that training, skill development, and research dissemination will improve research-action links between these two cultures. Rather, she proposed that the slow development of shared perceptions and a recognition of the value of each culture’s respective role will help the two groups to understand how to use each other more effectively. Murthy recounted her own experience as part of a team of social scientists and health policy-makers charged with solving health and population problems in backward states of India, and how this led to mutual learning and respect. These lessons are far more useful than what can be gleaned from a textbook or a course at Harvard.

**The health transition program**

How can a health transition program make a difference? Regrettably, but perhaps not unexpectedly, a blueprint did not emerge from the discussions. Rather, some general guidelines for the development of such a program were offered by the workshop participants.

First, a health transition program must struggle to improve the linkages between research and action. Either alone is unproductive and, in any case pure social science research and quite separate health interventions accompanied by operations research could be duplicative. Without a clear link to action, research may wander off into irrelevance. While basic enquiry of course has its place, it is not appropriate for a health transition program. Similarly, action or advocacy uninformed by research can be effective. In this case, however, a ‘pure action’ approach would simply duplicate the massive investments now being made by national governments and bilateral and multilateral agencies. The situation is too urgent to miss the chance to build capacity, knowledge, and linkages, thereby furthering the application of existing knowledge and creating new knowledge for health advancement.
A second guideline highlights the importance of program focus and coherence. Three days of discussions produced a clear conceptual map of the many directions that might be pursued. However, a program with finite resources must, at least at the outset, be more focused: in terms of the population to be served, the scientists to be involved, the types of problems to be addressed, and the research areas to be targeted. Increased focus can be achieved without rigidity, or the avoidance of risk, or dispensing with experimentation. Coherence is critical for a program in the early phases of development; especially where that program, given its inherently interdisciplinary nature, runs the risk of becoming diffuse.

There was nearly unanimous agreement that a networking strategy should be attempted in the health transition program. We may look to the renowned International Clinical Epidemiology Network (INCLEN) for an example of a successful network model. Networks can be fashioned in many ways. In the case of the health transition program, the network should foster exchange, nurture research capacity (especially in developing countries), and promote the development of shared values and common purpose among its members. But these questions remain: how should the network promote the collection and analysis of data, and the dissemination of research products? How can the network help to increase the pool of social scientists interested in health research? Can partnerships be nurtured, not to pursue the unreachable goal of total equality of skills and resources among members, but to achieve mutual respect? How might the network improve access to information and the scientific literature for those cut off from the flow of data and ideas? Will the network approach encourage a more appropriate transfer of lessons from one setting to another? How should the network ensure that members derive professional satisfaction, as well as personal enjoyment, from participation?

Consistent with the network concept, is the notion of timely and adequate communications among donors. Gelia Castillo noted that programs similar to the proposed health transition program are currently being supported by a number of different funding agencies. Examples include the Social and Economic Research Group of the World Health Organization’s Tropical Disease Program, WHO’s Intersectoral Action for Health Program, the International Health Policy Program, and the health programs of the International Development Research Centre (IDRC) in Canada. The aim here is not to bring about ‘donor co-ordination’, an often-invoked, but rarely-implemented concept, but rather to encourage the sharing of information, the development of joint activities, and the focusing of attention on the needs addressed by this program. Better donor communication is essential to avoid overtaxing social scientists, especially in developing countries, where they are few in number but deluged with research opportunities.

A final guideline to be considered in developing the program is time. The workshop participants concurred that a health transition initiative does not fit the model of a two-year project funded by a government agency. It will require at least a decade of work to achieve the aims of the program: the building of capacity; the generation, completion, and dissemination of research; the construction of links between policy and action. The aspirations of the health transition program – conducting research, changing attitudes, enhancing capabilities – are too ambitious for a ‘project-model’ approach. Substantial time, and patience, are called for.

At a more concrete level, these guidelines might be implemented as follows: select a few key participants, develop a critical mass at a few centres within an international network, acquire some program momentum, and maintain a flexible, adaptive, and experimental posture. Include individuals with different backgrounds, because this program needs range and diversity. Introduce focus through regular topical, problem-oriented, or geographically-oriented workshops, perhaps at quarterly or semi-annual intervals. These gatherings could address sequentially the many unanswered questions posed in this workshop. Bring practitioners and policy-makers together with a few scientists (the reverse of this
workshop’s composition) to talk about links between research and action. Have a workshop on malaria control in the Amazon and include health planners, researchers, health-care providers, and leaders from the affected communities. Construct a network to address the question of how the linkage between women’s education and family health can be exploited in policy and programs. Through such activities, introduce some element of forward motion and progress, even as the longer-term agenda of capacity building is being pursued. A journal and a newsletter would be useful in keeping network members and other interested parties informed and involved.

The success of the program may revolve more around the engagement of young people than the production of research. The true test will perhaps be the number and quality of junior scholars who are attracted to this enterprise, as this generation will emerge as the leaders of the Health for All movement – not by the year 2000 but certainly by 2025.

The performance of the health transition program should also be evaluated. The evaluation should include not only self-assessment by network members and the funding agencies involved, but also input from external participants. No formal evaluation, however, will replace the need for faith. There are no cost-effectiveness studies to prove conclusively that a health transition program should be undertaken or that it will generate high health impact at low cost. Rather, the participants will need to trust that what they are engaged in is worthwhile, and that it can indeed make a difference in people’s everyday lives.

Finally, this workshop, as exciting as it has been, represents only one step in a journey. We are eager to begin. In the meantime, perhaps I can respond to Kenneth Prewitt’s request for alternative names for the program of activities we hope to undertake. The concept of the ‘health transition’ was coined by Jack and Pat Caldwell, intellectual pioneers in this field. Some consider the term too neutral or static: ‘The Health Transition?’ But other titles seem too nondescript: ‘Accelerating the Health Transition’, or ‘Social Research and Action for Health’, or ‘Health and Public Policy’. Perhaps, as Elias Sevilla Casas implied, a most appropriate title would be: ‘A Health Transition for All’!

The Nigerian health transition program

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Following a two-day Planning Meeting of principal investigators and Steering Committee members held at Ibadan on 26–28 November, 1990, the Nigerian Institute of Social and Economic Research (NISER), Ibadan, has submitted a research agenda on health transition (the social and cultural determinants of health) to the Rockefeller Foundation for funding.

The aims of the research program are:

1. To study people’s beliefs, perceptions and attitudes about modern medicine, health facilities and preferred services.
2. To study how people perceive, evaluate and act at the onset of illness, particularly in the case of children’s illnesses.
3. To examine the resource allocation pattern within the family and determine the person or persons responsible for children’s health maintenance, the proportion of the family’s budget that goes to health and the choices that have to be forgone.
4. To attempt case studies of illness in order to find out who first noticed the sickness (especially in the case of children), how long it was before any treatment was given, whether home treatment was first employed and what it was, how the decision was made to go to a healer for treatment, what kind of healer was chosen, and who and what influenced the decision.

5. To study health providers with a view to understanding who they are, and where and how they are trained; whether people go to different healers for different types of disease; how long patients have to wait for treatment; whether a patient’s level of education influences the time each patient spends with a healer, and whether patients follow the instructions of healers.

6. To examine how maternal education results in better health care and child survival.

The most significant outcome of the Health Transition Program will be the subsequent intervention program. Through the intervention programs, the health seekers and the community will be sensitized toward appropriate health-seeking behaviour by means of education, publicity and health visitors. Medical personnel will be encouraged toward more egalitarian use of their time and will provide adequate information and instructions to patients.

It is believed that the findings of the research program will enable the government to adequately monitor the health-care providers through supervision and education, and enable the people to derive optimum benefits from the resources put into the health-care system.

A team of twenty researchers in the field of health and related disciplines, from twelve institutions in Nigeria, has expressed interest in participating in the program, which will be located in the Nigerian Institute of Social and Economic Research (NISER), Ibadan, and co-ordinated by Professor I.O. Orubuloye, of the Ondo State University, Ado-Ekiti, Nigeria.

The first stage of the program will last for eighteen months.

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