Action Against INFECTION

A newsletter for WHO and its partners

EDITORIAL

Health research and disease control: two different cultures, one common goal

by Dr Carlos M. Morel, Director, Special Programme for Research and Training in Tropical Diseases (TDR)

Health research and disease control are sometimes regarded as competing, rather than cooperating, activities. Therefore it is not unusual to hear about the "divide" that "naturally" separates them or about the reasons for its existence – researchers perceived as doing research "just for the sake of research", and control managers seen as "not interested in research".

Is it true that health research and disease control have different cultures? Yes, it is very true. Is it true that they do not cooperate? This has happened, but it is not a law of nature. Is it true that they have different goals? In the short term, maybe; in the long term, definitely no.

The relationship between research and control has been a recurring theme in health and in the history of TDR. The second External Review of TDR stated that the Programme's work would have to include the demonstration of the utility of the tools in their intended setting of use… and the initial exploration of the most appropriate means of their application. The interpretation of this was that TDR's mandate would have to edge closer to the borderline between research and control. In other words, TDR would do research and development of new tools until a demonstration – the proof of principle – were obtained, but would never cross the borderline between research and control.

The third External Review, completed in October 1998, found that this approach was clearly not working and concluded that the relationship between research and control needed fundamental restructuring. Therefore it requested TDR to develop a long-term vision and a strategic plan that would set the overall context for TDR priorities.

A radically different conceptual framework was adopted in TDR's new strategy for 2000-2005 (see page 2), formally approved by the Joint Coordinating Board in June 2000:

- It does not recognize the existence of borderlines between research and control – instead, it calls for a seamless interaction between the two activities.
- It stipulates that TDR has to go **beyond** obtaining a proof of principle and get involved in implementation research – the research needed to move new interventions towards real-life use by the health systems, control programmes and end users.

This new conceptual framework, now being implemented, represents a dramatic and radical broadening of TDR's classical mandate. Traditionally, TDR has interacted primarily with the academic sector – research institutions, universities – funding research projects aimed at the development of new tools, and simultaneously strengthening the research capacity of disease-endemic countries. This ini-

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tial strategy has paid off, and TDR's accomplishments in its first 25 years of existence have significantly contributed to the control and/or elimination as public health problems of four tropical diseases: leprosy, filariasis, onchocerciasis and Chagas disease. But it is no longer sufficient today.

New WHO policy shows us the correct direction. We have to move away from needing to choose between research and control. We have to address and work synergistically in both of these areas, which have different cultures, habits and tools, it is true, but which aim at the same and undisputed goal: reducing the burden of disease and improving public health around the world. Synergy of research and control working together in health has tremendous potential for making a real difference for the world's poor and marginalized populations, and that is now a major guiding principle for TDR's future actions.

The new strategy, now being implemented, will bring TDR to an exciting new phase. One of its main tasks is to move WHO away from the false dilemma - **research or control?** This false dichotomy was pointed out by WHO's Director-General when she stated:

"WHO has to relate to two time frames. One is immediate. Member States have immense problems today, and cannot be asked to wait decades for their solution. They need and they want action now. Roll Back Malaria and the Stop TB Initiative both address this issue. There are no ideal tools to fight malaria or tuberculosis – but this is no excuse to delay action.
The other time frame is long term. We must keep alive the dream of developing new and better tools for the future. It is because we lack them, that developing new tools has to be a top priority. In short: we have to act now with what we have at our disposal; and we have the responsibility for fostering the development of new and improved tools against the problems of today and tomorrow."

TDR'S new strategy

The new TDR strategy was shaped to address the issues raised in the Editorial above. It is synergistic with WHO's new corporate strategy, which strongly endorses the role that research and new knowledge should play in disease control, and is based on the following main elements:

- A reinforced focus on implementation research, or the research needed during the introduction of a new tool into disease control by the health systems of disease-endemic countries.
- Full exploration of the new opportunities provided by science and technology - such as genomics, bioinformatics and high throughput screening - which open new ways for accelerated discovery of new drugs, vaccines and diagnostics, as well as new perspectives for vector control.
- Exploration of new opportunities of collaboration through public-private partnerships.
- A renewed emphasis on social, economic and behavioural research to achieve a better understanding of the limitations and opportunities posed by contextual factors to control and prevent tropical diseases.
- Greater involvement of researchers and institutions from disease-endemic countries in all areas of TDR activity, with a strong emphasis on institutional strengthening.
- Intensive use of new information and communications technology.

TDR's traditional strategy, albeit successful, is no longer sufficient

- *Some of the traditional TDR diseases, as well as new (emerging) diseases are imposing an increasingly heavy burden on poor countries and marginalized populations, owing to several new factors such as emergence of drug resistance, increased travel, migration and displacements.*
- *TDR's pipeline of development of new interventions, nurtured during its first 25 years of existence, has been generating large numbers of products, which can be tested and moved downstream – to the field. In other words, TDR has become a victim of its own success, lacking the necessary capacity and contacts to move products downstream at an appropriate speed.*

Ebola strikes Uganda

Global outbreak alert and response network responds immediately

On 8 October, the first cases of Ebola haemorrhagic fever were reported in Gulu district in northern Uganda, about 75 km south of the border with Sudan. The Ministry of Health turned to WHO's outbreak response specialists at once. Thanks to contingency funds from Germany, Ireland, Japan and the Netherlands, a WHO team was able to offer immediate support to the doctors, nurses and staff at Gulu and Lacor hospitals to contain and control the Ebola outbreak.

The outbreak has now been successfully contained with the help of partners in the Global Outbreak Alert and Response Network, including UNICEF, World Food Programme, International Committee of the Red Cross, *Médecins sans frontières*, Epicentre (France), Centers for Disease Control and Prevention (United States) and the *Istituto superiore di sanitá* (Italy). Additional financial support, materials and personnel have been provided by Canada, Denmark, Germany, Ireland, Japan, Norway, South Africa, the United Kingdom and the United States.

Massive effort against diseases of poverty

First advocacy forum, Winterthur (Switzerland), 3-6 October 2000

This forum was the first in a series of steps driven by a vision: if the world wants to take a serious stand against such leading killers as HIV/AIDS, malaria and tuberculosis, a much greater social and political movement must be built.

The forum brought together some of the world's successful advocates who have shown a track record of being able to lobby, publicize and build advocacy partnerships. It was attended by around 200 participants, a unique mix of public and private sector advocates, communications experts and disease specialists.

As most aspects of the massive effort against diseases of poverty continue to unfold, the forum provided an opportunity for participants to engage in discussion with each other and with senior officials of WHO and UNAIDS. At the official opening of the forum Dr Brundtland (Director-General of WHO) and Dr Piot (Executive Director of UNAIDS) were also able to share their vision for the way forward in the fight against diseases of poverty.

During the forum, various plenary sessions took a critical look at lessons learned from global advocacy. Group presentations focused on worldwide examples of best practice. Various organizations from the private sector show-cased examples of how the public and private sectors have worked together to scale up efforts against these diseases of poverty. Working group participants were able to exchange ideas, debate the issues and start outlining advocacy plans for the massive effort movement.

Vector control

Global Collaboration for Development of Pesticides for Public Health (GCDPP)

This is a unique collaboration of the commercial and public sectors to address the increasing challenges of vector-borne disease, under the auspices of the WHO Pesticide Evaluation Scheme (WHOPES).

Environmentally sound new insecticide products are required for public health use. It is unlikely that such new products will emerge from traditional sources without a major initiative driven by a partnership such as GCDPP.

For more information, see **http://www.who.int/ctd/whopes**

Rift Valley fever (RVF)

Reported for the first time on the Arabian peninsula

RVF was first recognized in Kenya in 1930. Outbreaks outside sub-Saharan Africa have been described in Egypt in 1977-1978 and 1993. A large outbreak occurred in East Africa in 1998. The current outbreak, which has occurred in the border area between Saudi Arabia and Yemen, represents the first documented evidence of RVF virus transmission outside Africa.

Communicable disease surveillance and response (CSR)

New director appointed

Dr Guénaël Rodier, from France, took up duty as Director, CDS/CSR in Geneva on 1 August 2000. After extensive experience in developing countries, he joined WHO in 1994 where his work focused on epidemic response (e.g. plague in India in 1994, and all Ebola/Marburg outbreaks since Kikwit, 1995), national surveillance systems and capacity building. He has led the Integrated Disease Surveillance and Response team since 1996. In his new post, his main objective is to continue to safeguard international public health security, building on existing WHO activities, a global partnership and a multi-disease, multisectoral (or integrated) approach for the control of epidemics, emerging infections and drug-resistant diseases.

Dr Guénaël Rodier new Director, CSR

Global Salm-Surv

Salmonellosis and antimicrobial resistance surveillance

Initiated in January 2000, Global Salm-Surv is a collaborative project of the WHO Communicable Diseases cluster, the Centers for Disease Control and Prevention (United States of America) and the Danish Veterinary Laboratory (Copenhagen). It is a global network of over 260 individuals from 194 laboratories in 101 countries, involved in surveillance of *Salmonella* from humans, food and animals. The primary goal of this network is to strengthen the *Salmonella* surveillance capacities of national and regional laboratories. Information is shared between laboratories and individuals via email, world wide web, electronic discussion group and/or fax.

Training courses on surveillance of salmonellosis and antimicrobial resistance in *Salmonella* are also organized, in order to lay the foundation for participation in a regional laboratory network. Courses have been conducted in Bangkok, Thailand (November 1999); Buenos Aires, Argentina (June 2000); Crete, Greece (July 2000). In all, 31 countries have participated in these courses to date. Other courses are planned to take place in January 2001 (Argentina, China, Greece, Mexico, Thailand).

For more information please see: **http://www.who.int/salmsurv.**

NEWS FROM PARTNERS

Professor Chitta Ranjan Choudhury, Head, Centre for Oral Disease Prevention and Control, writes to us from Mangalore, India. Currently, the Centre is focusing on the area of infection and cross-infection in oral health care settings, by carrying out a number of studies (e.g. on the attitude and prevailing practice of dentists for self-protection from cross-infection). Professor Chitta Ranjan Choudhury would be happy to be in touch with any other experts/researchers involved in similar activities, and more particularly those concerned with the oral manifestations of AIDS and HIV infection, and oral cancer.

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appears in English, French and Spanish

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