In this number

Neocolonialism and epidemiology

The International Conference on Health Research for Development celebrated last year in Bangkok provided the stimulus for a special issue of the *BMJ* related to global health and the governance of global health research was discussed. Several papers emphasised the need to turn round the inequitable nature of health research. The effect on health research of the interests and conditions posed by the international funding bodies was considered also as an important concern.

There is a general agreement on the need in producing high quality research that tackles the major health problems of developing countries. However, matters related to the theories that drive the research and how these theories and methodological approaches affects health policy making are not frequently considered.

The *JECH* has published papers and debates on epidemiological theories. In this issue we welcome an especially important debate: the way in which institutions devoted to international development create a discourse that influences the conduct of epidemiological studies is examined. A paper by Luis A Avilés has been an occasion to trigger off the debate. Four invited commentaries approach the topic in a greatly diverse way.

The paper by Avilés is a case study based upon the *Epidemiological Profile*, a document sponsored by the United States Agency for International Development (USAID). According to Avilés, the USAID report illustrates how epidemiological assessments are imbued with theoretical assumptions shaped by the institutional setting under which the research is conducted thus resulting in a neoco-

lonial practice of epidemiology. Charles Poole, using the same documents discusses the points raised by Avilés and poses some interesting and difficult questions. Mauricio L Barreto, Naomar de Almeida-Filho and Jaime Breilh highlight the contribution of Avilés' paper as a reference regarding the misuse of epidemiology in the context of international politics. They also point out a relevant aspect of Avilés' paper. According to them the paper fails to build a North-South partnership omitting the intellectual efforts of Latin American scholars. Paula A Braveman, provides an excellent example showing how a recent shift in the epidemiological approaches used by researchers at an international agency may both reflect the underlying assumptions and reinforce the practice of neocolonialism. She also claims for more rigorous scrutiny and open debate on the assumptions that underlie the epidemiological analysis. Finally, Tim Lang, after describing the present world situation as neo-mediaeval, demands our compromise in providing an evidence base for just and equitable public policy and practice.

Clearly this debate is not finished with these contributions, the international epidemiological community needs an open space for further discussions in this topic. The *JECH* will be receptive in the future to contributions adding perspectives to the questions posed in this issue: is epidemiology a colonial biased science?

ILDEFONSO HERNANDEZ-AGUADO
Deputy Editor

Speaker's corner

A note to Bill Gates

Dear Bill

Just as Ted Turner with his one time gift of US\$ 34 million to the US State Department has recently bailed out the US government with regard to its outstanding dues to the UN (supposedly negotiated in 10 minutes between him and Richard Holbrooke) so have you bailed out global health. In the short period of three years your Bill and Melinda Gates Foundation has supported global health development in your areas of choice (vaccine development and maternal and child health). The budget of the World Health Organisation pales in comparison. You should be praised for this commitment. One of my students suggested that you get the Nobel Peace Prize, together perhaps with George Soros and other global health philanthropists. But the news is not just positive and that is why I am writing this new year's note.

Global health challenges are no longer the exception they are the rule. An ad hoc response system run on good

will and philanthropic largesse like yours can only be an intermediary step. Already the law of unintended consequences is starting to have its effect. Newly established global disease investment funds, run from office suites in New York, Washington, Geneva and Brussels are set to fund raise, compete and conquer, each seeking contributions in the billions of dollars from the same sources for "their" disease. Their start up venture capital usually comes from your foundation. Perhaps the public health community needs to get used to the fact that the best way to fight the diseases of the poor is to allow a lot of people to get rich while doing it. Lets commodify it and make it really attractive for investors by making it really threatening.

I agree that urgency, flexibility, marketing and innovation are indeed crucial to solve the global health challenges, and it was really high time that some high power energy entered the global health arena. But, like Macchiavelli, I

still believe in the importance of foresight and good governance. Global health also needs transparency, accountability, legitimacy and respect for due process. And some of those processes are downright tedious, boring and very long term as the World Health Organisation can testify. Yet they need to be done.

I know you don't like being bored. But I need to say it all the same. We need an operating system for global public health that allows us to do both the tedious and the exciting things without getting in each others way too much. At present we lack a global public policy on health, we lack an effective and participatory governance structure and most importantly we lack a financing mech-

anism that ensures continuity and allows large scale impact. All the things I guess a big global company worries about all the time. That explains my wish for the new year. The next big challenge for global health is not yet another disease initiative. John Maynard Keynes helped invent the United Nations. Bill, go the next step and invest your creativity, resources and influence to help create a financially viable network structure fit for global public health in the 21st century it. Then you would really deserve the Nobel Peace Prize.

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Editorial

Mégapoles Project: working on behalf of socially disadvantaged groups

Social disadvantage can lead not only to poverty but can reduce a person's ability to engage effectively in mainstream society.^{1,2} For a number of years a variety of public health models have sought to tackle inequalities. These include the declaration of *Alma Ata Health for All*, the *WHO Healthy City* movement, now almost 15 years old, bringing together a worldwide network of cities that have exchanged information and experience in tackling the determinants of health. Experience from these initiatives' promotion of targets for health improvement, cooperation, collaboration and partnership working at city level is seeded within the joined up working and thinking that is dominating "third way" governments' strategies for health improvement in the developed world.

Important steps for information exchange in Europe have yet to facilitate sufficient knowledge and information exchange about public health models, activities and projects that are in place and their true impact on the health and welfare of those living outside the mainstream of society.

In 1997 Stockholm County Council put forward a proposal to develop a network of health executives and politicians from the capital cities in Europe to DGV in the EU. This networks' aims would be to find effective means of achieving better health and reducing inequalities. A steering group was formed with health representatives from Stockholm, Vienna, Amsterdam and London and three sub-networks were created to focus on three priority areas socially disadvantaged groups, children and young families and older people. Three years later some early fruits of this network are beginning to appear.

The Socially Disadvantaged Group Sub-Network of Mégapoles enables those working as health executives and health mayors of capital cities across Europe to exchange information, knowledge and best practice, with particular emphasis placed on practical work and support at the community level.

The focus is immigrants, ethnic minorities, refugees, the homeless and people with drug addictions. To date the projects visited provide support to homeless people, drug misusers, prostitutes, immigrants and refugees, the disadvantaged and those suffering from domestic violence.

Socially Disadvantaged Group Sub-Network members are able to:

- raise the profile of projects in their own cities.
- gain a better understanding of the problems experienced by the socially disadvantaged.
- learn how other cities tackle problems and to identify best practice.

Members want to see real projects in action rather than just theory. They hope to be in a position of influence as a result of the Socially Disadvantaged Group Sub-Network experience.

At an early stage in the Socially Disadvantaged Group Sub-Network, it was realised that participating cities did not take the same approach to collecting and interpreting information about city populations nor disadvantaged groups. Lisbon for example describes homeless people as those without "conventional and fixed homes" who sleep in private and public sectors. Berlin's definition distinguishes between people without regular housing, those who live in the street and are termed as roofless and those who are not yet de facto homeless but live under unacceptable housing conditions. In cities such as Madrid, Stockholm and Vienna, minority groups are defined in terms of foreign citizenship, while London uses census based reporting by people of their ethnic or racial group. For some cities the desired information is not available—Dublin for example does not have a suitable question on its national census to identify minority groups.³

The Health of Londoner's project was commissioned to facilitate the collection of data at city level by the Steering group in 1998. Despite the inconsistent definitions of key parameters such as homelessness and ethnicity making comparisons difficult the resultant report *Health in Europe's Capitals* has allowed for the first time ever comparisons of health and social indicators at capital city level across Europe.⁴

The Socially Disadvantaged Group Sub-Network have developed a standard approach to project analysis. Meaningful comparisons can now be made about the funding, the structure and the success of each project. The network meets on a regular basis to discuss projects the

group believes are effective in tackling social disadvantage. Each member takes it in turn to organise the logistics of a visit to projects in their own city. Members visit and assess projects using the standard evaluation methods. Members of the network discuss the evaluation and results are fed back to project leaders, the member from the host city and other Mégapoles networks.

The projects visited in Europe's capitals were:

- Homelessness: Berlin, Dublin, Lisbon, and Stockholm
- Drug misuse and rehabilitation: Dublin, Helsinki, Madrid and Stockholm
- Prostitution and health care: Berlin, Lisbon and Madrid
- Health among socially disadvantaged groups: London and Brussels
- Health interventions for immigrants and refugees: Brussels, Lisbon, London, Madrid and Stockholm
- Domestic violence: Helsinki.

The practical experience from reviewing the projects backs up the findings from researchers. The most effective ways to tackle these issues are to:

- (1) tackle the wider causes of social disadvantage
- (2) tackle the harmful effects of a person's environment
- (3) promote social support mechanisms
- (4) meet the health care needs with accessible, appropriate and effective services

Furthermore, there is value in a network of health executives at city level,

- (1) it can influence policy and decision makers
- (2) it can create new approaches to practical problem solving
- (3) it is possible to transfer principles and practical aspects across Europe
- (4) it can compare performance across Europe

Messages to policy makers

So what are the key messages from the members of the network? What would make a difference to the health of social disadvantaged groups? Many of the initiatives and projects visited in Europe's capitals are small scale, based outside of the statutory sector and subject to insecure funding. However, it is often these organisations that operate outside of the statutory sectors such as non-government organisation that can have the most impact with these groups. Small specialist projects can be much more innovative and able to respond to their needs specifically and sensitively.

In the future the role of the statutory (government and city level) sector should be to be systematically supportive, to commission and secure funding for these groups rather than to provide the service itself.

There is a need to foster and facilitate the capacity and capability within non-government organisations and projects, support the development of social entrepreneurs and recognise that building up from individual projects can be most cost effective.

If politicians are interested in tackling social exclusion and improving health, they will certainly be interested in knowing how their city compares on key health and social indicators and if their city's participants in the project have learnt anything from taking part.⁴

There are similar issues about disadvantaged groups in European capital cities, for instance refugees and immigrants flock to capitals. If comparisons are to be valuable they need to be continuously updated and validated. This is outside of the funding structure of the Mégapoles project but there may be an opportunity to develop routine information exchange at city level if this idea is taken forward as part of the new EU public health strategy.

Among the practical examples of projects illustrated in a recent Mégapoles publication: *Working with socially disadvantaged groups. Learning from cities across Europe* are:

- Lisbon's prize winning project Quinta do Mocho, which arranges an integrated approach across five ministries to ensure that the health, education, work and cultural requirements of immigrant groups are met.
- Forest Quartiers Sante an umbrella project based in Brussels that covers a range of community based activities in one area of the city, funded by the French Community. It aims to encourage people to take a more active part in their own health care.

But probably they will be most heartened by the quotes of participants as Nicole Aerny Perreten from Madrid who praises a London project—Croydon's Think Tank in the document "...Tackling as many health determinants as possible is an essential strategy in the fight against inequalities in health. There is growing awareness of this need in Spain. I think Croydon presents an excellent practical example of what can be done to reduce such inequalities".

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- 1 Acheson D. *Independent Inquiry into Inequalities in Health Report*. London: The Stationery Office, 1998.
- 2 Wilkinson RG, Marmot M. *Social determinants of health—the solid facts*. Copenhagen: WHO 1998.
- 3 Dalziel M, et al. Project Mégapoles: promoting better health for socially disadvantaged groups across Europe. *European Journal of Public Health* 2000; 10:228–300.
- 4 Project Mégapoles. *Health in Europe's capitals*. Luxembourg: European Commission DGV-Directorate General, Employment and Social Affairs, May 1999.