THE IDRC IN HEALTH AND POPULATION:
A REVIEW OF INTERNATIONAL RESEARCH

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It is a pleasure to have an opportunity to talk to this distinguished
group about the work of the International Development Research Centre in
the fields of health and population. Our programs are new and still in
the process of development and expansion, but I feel that we have enough
experience now to give some general indications as to our direction and
the kind of impact that we are having or hope to have in the future.
Several of you here have helped us in the elaboration and execution of
our program, and I hope will continue to be collaborators and friendly
critics of our efforts.

A few brief words about the IDRC. It was created in 1970 by the
Canadian parliament as a public corporation, with the primary objectives
being "to assist the developing regions to build up the research
capabilities, the innovative skills and the institutions required to
solve their problems; and to foster cooperation in research on develop-
ment problems between the developed and developing regions for their
mutual benefit." This very broad mandate was placed in the hands of an
international Board of Governors, half of whom are Canadian, the
remaining half drawn from both developing and developed countries outside
Canada. At present, six of 21 Governors are from developing countries.

In the four years of effective operation, the IDRC has determined
major strategies and fields of concentration. Population and Health
Sciences is one of four divisions of the Centre, the others being concerned with agriculture, social sciences, and information sciences. In pursuing the broad objectives of the Act of Parliament, we have attempted to focus on the problems of rural peoples, and to be primarily receptive to the needs and priorities expressed by governments and institutions in the developing world. We have made every effort to support research in those countries, undertaken by nationals of the developing world, in order to build up their own research skills.

In practice this has not been an easy task. In some developing countries a strong layer of qualified scientists exists, and in these countries there has been great willingness and enthusiasm with IDRC collaboration. In others, where scientific skills are rare or absent, our staff has spent a great deal of time in attempting to elucidate research priorities, and then helping local authorities evolve research programs with a good deal of outside support. Clearly, in these regions, we cannot expect to sit back in Ottawa and have high quality research projects arrive on our desks.

On the other hand, we have been extremely sensitive to the charges made in many parts of the world that research has been conceived and undertaken by Western scientists with minimal or no involvement of developing country nationals, and with little benefit to those countries. This has been particularly true in the social sciences and in the area of operational research, demonstration and pilot projects, and especially in population problems.
The response to this approach has been extremely positive. In a number of cases we feel we have turned around the traditional dependent arrangement between developing and developed countries, whereby the Third World scientists are largely beholden to outsiders for funds, ideas, and implementation. So often this has meant a lack of involvement and in many cases, a lack of relevance in the research. Frequently, research findings have not been translated into policy or action.

A corollary to this general approach has been that the IDRC has only indirectly involved Canadian scientists in its activities. Although a number of Canadian individuals and institutions have been involved in providing technical support in the implementation of research overseas, there have been very few direct grants made within Canada. There is no intention to discriminate against Canadian researchers, but simply a decision on the part of the Board of Governors to place maximum emphasis on building up the scarce human resources and research capacity in the developing world. In recognition of the need to strengthen Canadian scientific capacity, IDRC has established a fellowship program designed to increase the number of qualified Canadians involved in international development.

In brief, these are the general policies of the IDRC as they have evolved over the four years. I would like to turn now to the Population and Health Sciences division, and highlight a few of the program areas that we have been developing. In choosing Population and Health, the IDRC Governors were reflecting worldwide concern at the problems arising
from rapid population growth and distribution, and the problems of high mortality and inadequate health that exists in many parts of the world. They also recognized the importance of looking at these two areas together. In fact many of the present practical problems of development have arisen from treating these two areas in isolation, and not recognizing the interrelationships between inadequate basic health services, poor nutrition, high infant mortality, family planning, and rapid population growth. In all our activities we have tried to bring these two areas together, and indeed many of our projects are integrated health and population projects.

In the past four years the Population and Health Sciences division has made a total of 50 grants, totalling $7.0 million. Researchers and governments in over 30 countries have been involved in these projects. The range of activities has been intentionally kept broad, covering research on population policy, dynamics of population change, family planning action research, improved methods of fertility regulation and contraception, basic health care delivery and health manpower, and infectious disease and rural sanitation. This has been essential if we are to be receptive to the requests and needs of developing countries. On the other hand, we have eliminated a number of areas, particularly clinical research, and placed greater emphasis on some parts of our program than others.

What have been the achievements over this time? In international research, four years is simply too short to evaluate all but a small handful of individual research projects that we have supported. Indeed,
the bulk of grants have been made in the past two years, and almost all of these are still ongoing. I would like to attempt to highlight a few of the areas where we feel we are moving in the right direction and where we hope we are making some impact on general development efforts. These are tentative observations, and should be taken as such.

In the health sciences field, our major focus has been on seeking innovative ways to develop rural health care delivery services, primarily with the use of health auxiliaries. We have supported research projects in five countries to demonstrate and evaluate the effectiveness of different categories of health auxiliaries, or to help establish programs for training of health workers. Our experience has been that this field has been surprisingly neglected in the past, and that there is a rising level of interest and involvement in it. A number of countries are realizing that they cannot in any way develop a Western-style physician-based hospital-oriented national health care program, and that the training of more doctors is simply not the answer, even if funds were available. I have just returned from Nepal, one of the poorest countries on earth, where we have supported a health manpower study in connection with a newly created Institute of Medicine. This Institute is focussing entirely on the training, deployment and evaluation of basic health auxiliaries, and largely ignoring the higher level of health personnel. In fact, the government made a conscious decision some time ago not to build a medical school, and Nepal still does not have one although its population is over 12 million people. The government is sticking to this policy despite pressures from the medical
profession and others to build more hospitals and develop a more Western style of health care. (The limited number of Nepalese doctors are mostly trained in India and in Eastern Europe. More and more, Nepalese authorities are favouring Russia and Eastern European countries for their training, simply because the doctors will return to Nepal after graduation.) The health policy is totally integrated into the overall development planning of the country, and is seen to be an integral part of rural development. Less than 10% of the population lives in cities. This policy is a difficult one to follow, and the results will only show in the mid- to long-term, but it is seen to be, after careful analysis, the only rational approach that can be pursued in Nepal.

There are a small number of countries like Nepal that have made this conscious decision. In many others however, where Western-style medicine is well established, resistance to change is tremendous. This is true in most of Latin America where a very large number of medical schools exist and where the overwhelming trend is towards specialization and hospital-oriented health care, with rural areas largely neglected. In addition, the brain drain problem is enormous, and it is calculated that the equivalent of one medical school in Latin America does nothing but train physicians for the United States. As all of you know the cost of creating and operating a medical school is exceedingly high, this constitutes a major aid program from Latin America to North America. The IDRC has collaborated with the Pan American Federation of Faculties of Medicine, of which ACMC is a member, to examine health manpower policy at the highest levels and to seek new alternatives in health manpower.
training and delivery of health services, with attention to the rural areas. A major Latin American conference is being held with IDRC support early next year, and will bring together health planners, Ministry of Health officials, and deans of medical schools in an attempt to find new solutions.

Many elaborate rural health care demonstration projects have been established, researched and evaluated over the past decades. The globe is littered with them. But for the most part, their "demonstrations" are never taken up by political authorities, for reasons of cost and antagonistic political pressures. IDRC is making every effort to overcome this problem in the projects it funds by assuring direct participation of appropriate authorities, and by building in from the outset primary objectives of low cost and replicability. Such a project is underway in Colombia, where university, state and federal authorities, and the government agricultural development agency are all collaborating in a major rural development effort, with health as one component.

We have found these and other developments very encouraging. There is clearly an increased interest in health as a neglected area in the development process. However, the pressures to develop highly specialized services in developing countries is enormous. Governments seem to want the kind of services that they find in the private clinics of Paris, London and New York, even if that means incredible expense, and services available for a tiny percentage of the population. I am not sure if these pressures are being deflected significantly, or whether there is a
real trend towards looking at alternative health care delivery systems, but I would like to hope so. Certainly other agencies in addition to IDRC are moving into this field, including CIDA, and we hope that research projects that we are supporting will provide sound scientific information on the usefulness and most effective deployment of health auxiliaries, and ways to distribute health care more equitably. In the absence of other improvements in the quality of life of the rural poor, however, I am by no means certain that even these efforts will make a difference.

Turning to the population field, I feel our efforts, although greater, have been less encouraging. This is because of the complexity and intractability of population problems, their varied nature in different parts of the world, and the political and individual sensitivities that inevitably surround this field. In addition, the efforts of other international agencies have been very large in this area over the past decade, and in some ways IDRC's involvement has followed along in the footsteps of other efforts. We have nonetheless attempted to break away from some of the past directions, particularly in terms of our general style of operation, and have received considerable encouragement from developing country scientists. Obviously, we are not any further along in finding solutions to the range of population problems that exist. Our approach has been to support research seeking to place population problems in the context of other development issues, to seek to examine relationships between population dynamics and other sectors including health, education, agriculture and employment, and to broaden
the concept beyond the delivery of birth control techniques. This
approach has been now officially adopted at the World Population
Conference in Bucharest earlier this year. In that respect (unlike Dr.
Bruce-Chwatt) I feel that the Bucharest conference was a positive one,
in recognizing that there is no simple solution to population, nor is the
reduction of population growth rate going to automatically solve develop­
ment problems. For those who see population problems in "explosionist"
terms, of course Bucharest was a failure. I did not have high expecta­
tions, and therefore was pleased at the way that the population debate
was opened up, and some political differences were resolved. I hope that
developing countries will re-examine their population strategies in light
of the Bucharest pronouncements, and continue to press forward in this
field but on a broader and more integrated basis. In any case, this is
the direction that our research has been taking us.

One of the innovative areas that we have been involved with is
research into the determinants of fertility. That is, the motivations
for continued high fertility. Research is underway in six Southeast
Asian countries on the psychological value of children to parents, in
trying to determine why parents want to have children, what are the
positive and negative attitudes towards child-bearing, and what are the
underlying individual and cultural pressures that create this motivation.
Anthropological, psychological, sociological and economic research tech­
niques are being employed, with the hope of gaining more fundamental
understanding of basic motivations. This research is exploratory and
innovative, but we have considerable hope that it will shed new light
on this area, which has been surprisingly neglected considering the
tremendous resources put into the population field in the past period
of time.

The Centre is moving more and more into policy-related research,
seeking linkages between population dynamics and other aspects of develop-
ment. A recent study will be looking at the relationship between female
education and fertility, and the reasons why in many countries female
literacy remains so low. It is well known that a strong inverse
relationship exists between female literacy and fertility, and if ways
can be found to increase female education, it is reasonable to assume
that birth rates would drop more quickly.

The basic debate goes on however: Can we affect fertility in the
absence of other significant development advances? There is no simple
answer to that question, although evidence in the number of countries
indicate that yes, we can influence fertility to some extent, but that
fertility rates drop much more quickly in countries that are moving ahead
rapidly on other development fronts. Are there specific areas in the
broader development field, such as female literacy, that could be
tackled and improved in order to decrease fertility? These are the type
of questions that we are seeking to answer in our research programs.

Finally, we are not neglecting the need for improved family planning
and contraceptive services and are seeking innovative research designed
to find new ways of providing information and services in family planning.