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SCIENTIFIC PLANNING GROUP  
ON EXPANDED PROGRAMME OF RESEARCH AND TRAINING  
ON BIOBEHAVIOURAL SCIENCES AND MENTAL HEALTH

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ADVISORY COMMITTEE ON MEDICAL RESEARCH

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Agenda item 8.3

PROGRESS REPORT OF ACTION TAKEN ON RECOMMENDATIONS  
MADE BY ACMR AT ITS TWENTY-THIRD SESSION  
WITH PARTICULAR REFERENCE TO  
MENTAL HEALTH

Scientific Planning Group  
on Expanded Programme of Research and Training  
on Biobehavioural Sciences and Mental Health

Report of the second meeting

Geneva, 28-30 June 1982

The second meeting of the Scientific Planning Group on the Expanded Programme of Research and Training on Biobehavioural Sciences and Mental Health reviewed the main issues arising from its previous work, from the work of the ACMR and its subcommittee, and from the deliberations of regional ACMRs which dealt with this matter.

The Group concluded that action should concentrate on developing a research infrastructure particularly in developing countries and on investigations in three priority areas: adaptation to rapid socio-technical change; alcohol problems (with special reference to research on preventive interventions in adolescence) and psychosocial aspects of primary health care (with special reference to technology of promotion of child and family health). A monograph on health and behaviour in developing countries will be prepared, as well as a series of short papers dealing with specific issues in the broad area of biobehavioural sciences and mental health.

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## 1. INTRODUCTION

At its twenty-first session, the Advisory Committee on Medical Research<sup>1</sup> recommended and the Director-General approved the establishment of a Subcommittee on Mental Health and Neuropsychiatric Research. The subcommittee subsequently recommended a long-term WHO programme of research in the field of biobehavioural sciences and mental health.

At its twenty-second session in 1980, the Global ACMR endorsed the subcommittee's recommendation and proposed that a Scientific Planning Group be convened to identify priorities for research and prepare specific plans for action.<sup>2</sup> The Group met in Geneva from 27-29 August 1981 and submitted its report to the ACMR in October 1981.<sup>3</sup>

The report was positively received by the ACMR, which strongly endorsed its main thrust. ACMR members suggested that emphasis be placed on the mental health components of primary health care, on gathering information about national research developments, and on the broad potential of mental health and behaviour research as a resource for medicine and public health. The ACMR also suggested several additional themes for consideration by the Scientific Planning Group, including:

- problems of violence;
- the impacts of rapid technological and social change on the family and other community institutions, and the implications of these impacts on health;
- involvement of young scientists in mental health and biobehavioural research programmes.

The Scientific Planning Group was asked to proceed with commissioning papers, convening workshops, establishing task forces and with other action necessary to develop proposals for the expanded programme.

In its work the Group took into account the relevant considerations of the WHO governing bodies, of the Global and Regional ACMRs and their subcommittees, of the Coordinating Group for the Mental Health Programme and publications and documents produced by the programme.<sup>4</sup>

The themes which emerged from this review and the Group's discussions can be summarized as follows:

- (1) In developing nations, as in developed ones, health and behaviour are indivisible. Individual and community patterns of water use, hygiene, nutrition, alcohol and drug use, and reproductive behaviour - to cite but a few - directly affect health for better or for worse.
- (2) The tightly focused categorical approach of WHO's other expanded research programmes (on tropical diseases, human reproduction and diarrhoeal diseases) is difficult to adapt to the area of mental health and biobehavioural science, because no one type of behaviour stands out as the single most significant threat to health in developing countries.

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<sup>1</sup> Advisory Committee on Medical Research, Report to the Director-General on its twenty-first session, held at WHO headquarters, Geneva, 19-22 November 1979 (ACMR21/79.11).

<sup>2</sup> Advisory Committee on Medical Research, Report to the Director-General on its twenty-second session, held at WHO headquarters, Geneva, 13-16 October 1980 (ACMR22/80.17).

<sup>3</sup> Advisory Committee on Medical Research, Report to the Director-General on its twenty-third session, held at WHO headquarters, Geneva, 12-15 October 1981 (ACMR23/81.10).

<sup>4</sup> For a selected list of background documents, see Annex 2.

(3) An important precursor for an expanded research programme is a systematic assessment of the burden of illness in developing countries that is attributable to psychosocial factors.<sup>1</sup> An accurate overview of the scope of the problem is vital to generating research interest and support.

(4) High priority should be given to epidemiological research efforts aimed at pinpointing behaviour-related health problems in specific communities, cultures, countries and regions. To conduct such research, rapid culture-sensitive assessment techniques of "community diagnosis" are needed.

(5) Despite the immense cultural variability that makes it difficult to devise effective means of influencing health-relevant behaviour, certain basic principles - such as principles of learning - can be applied universally.

(6) A central question to be addressed is one common to developed and developing countries alike: how to present the issues in a way which arouses and sustains the motivation of individuals and communities to adopt appropriate behaviours. It is important to identify programmes and practitioners who have succeeded and to analyse elements of that success which may be transferable with appropriate modification to other situations and cultures.

(7) Political obstacles are more likely to arise in the sphere of mental health and biobehavioural research than in the other WHO expanded research programmes. These need to be anticipated and weighed in the selection of foci for the programme.

(8) The development of a research infrastructure in developing nations is a key objective for the proposed WHO programme. Sustained collaborative arrangements with institutions in developed countries can be helpful in this regard.

(9) In both developed and developing nations, there is a need to encourage far greater cooperation and collaboration between biomedical and behavioural scientists. Institutional arrangements can foster integration of these sciences.

(10) WHO should be building upon existing institutions in the developing countries rather than seeking to establish new ones to conduct its expanded programme in mental health and biobehavioural science. Logical candidates include:

- (a) existing units already involved in psychosocial research;
- (b) strong medical research units that currently lack behavioural research components;
- (c) excellent clinical units now lacking such research capability;
- (d) research or clinical units in institutional settings where research is respected and supported.

(11) Behavioural scientists already contribute to many WHO programmes in, for example, human reproduction, child and family health. However, often these scientists work in isolation. There would be considerable advantages in the development of a programme of research and training in biobehavioural sciences and mental health which could facilitate linkage between programmes and make the pool of expertise more easily available for consultation by a variety of governmental and nongovernmental agencies.

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<sup>1</sup> A comprehensive review of the situation in the developed countries has been published recently and submitted to the Scientific Planning Group as a background document (Hamburg, D., et al., 1982: Health and behaviour, Institute of Medicine, National Academy of Sciences, Washington).

(12) Existing centres in developing countries, particularly if strengthened, might provide a useful focus for the kind of mental health and biobehavioural science research which is needed. These centres could also serve regional functions.

(13) Problems of particular interest to a variety of developing countries include: community participation and motivation for primary health care; nutritional concerns, including the effects of changes in breast-feeding customs; child neglect, abuse, and understimulation; effects on mental and physical health of changes in family structure that occur with increased industrialization, migration and uprooting; ways of changing hygienic practices related to drinking-water supply and sanitation; issues related to family planning; and the effects of mass migration (both within countries and across countries) and other major social changes on general health, family structure and individual psychology.<sup>1</sup>

(14) The Expanded Programme of Research and Training on Biobehavioural Sciences and Mental Health logically complements and is integrated with the mental health programme of the Organization. However, although directly related to the programme's objectives, it adds specific emphasis to a set of concerns and therefore deserves new consideration and support.

## 2. PRIORITIES FOR ACTION

### 2.1 Strengthening research capacity

A central goal of international research cooperation should be the strengthening of investigative capabilities within developing countries. Increasingly, research on health problems of developing countries has been conducted by indigenous investigators as part of bilaterally funded assistance projects or with the cooperation of scientists from developed and developing countries. Unfortunately, though, such cooperation has not always contributed to the formation of cadres of researchers within viable institutional settings. Underlying causes of this situation are multiple and complex, and are often not well understood by either the donors or the recipients of research funding. Possible factors include lack of long-term salary support for researchers, administrative posts held by part-time local investigators, and failure to translate research findings into relevant policy recommendations. Further, it is often not recognized that health research cooperation can take place not only between scientists from technically advanced nations and developing countries, but also between investigators from countries in the same area, whose populations are likely to share common health problems.

Special emphasis and long-term continuous support is required to nurture the development of scientific leadership in the developing countries. Assistance obtained from outside agencies must reinforce action directed to the development of such leadership capacity. At the same time, governments can lend support to scientific institutions by (1) encouraging research on urgent domestic needs; (2) supporting science departments within the universities and research institutions; and (3) encouraging the development of peer-review mechanisms through which to award research grants or training fellowships.

A recurring dilemma faced by those seeking to promote indigenous research capacity in developing countries is the need to train younger investigators and develop new cadres of researchers without compromising high standards of scientific investigation. This important aim was discussed in the 1981 report of the Scientific Planning Group and several options were formulated. In general, high standards are difficult to achieve without sound career opportunities being made available for those completing graduate work or speciality training. Most centres with international reputation for excellence have already received outside funding and, in fact, depend upon it for their continued existence. Strengthening linkages

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<sup>1</sup> See also the report of the first meeting of the Scientific Planning Group, pages 5-7, for a listing of possible priority concerns.

between such centres, government agencies, and appropriate private institutions might be useful in stimulating local support for health research relevant to national needs. Since various research training models have demonstrated their effectiveness in training health science researchers, it seems probable that no single model will suffice. A variety of research training devices must be utilized depending on the subject matter and level of seniority, on the countries' needs and on the available opportunities.

In more general terms, the following interventions of value for development of research capabilities in biobehavioural sciences seemed useful: (a) short intensive training course or workshops to sensitize multidisciplinary groups of qualified social, behavioural and medical scientists to basic concepts, methods, techniques and utility of biobehavioural research. Such courses can usefully centre on one major health problem to which the country gives high priority and which is amenable to behavioural interventions; (b) introduction of biobehavioural concepts in undergraduate and postgraduate levels of medical, social and behavioural sciences curricula; (c) engagement of Masters and Ph.D. students in medical, social and behavioural sciences to select mental health and biobehavioural topics for their theses and/or dissertations; (d) exchange of research experience and results between developing countries themselves in the area of mental health and biobehavioural sciences.

A fundamental condition for the successful development of a global programme of research is a continuous exchange of knowledge between professionals in developing and developed countries allowing research workers from both types of countries to share research skills and traditions. This, however, can only be provided in a useful way if the trainees have teachers who are reasonably familiar with conditions in and requirements of the countries in which the trainee is going to do research. An important requirement for training of research workers from developing countries in the industrialized countries would therefore be that experienced research workers from developed countries, or preferably small groups of such experts, spend - not too short - periods in the developing country with the aim of learning about the primary needs for research there, and about the possibilities of carrying out such research, before they begin their teaching of trainees from such countries.

An important prerequisite for effective cooperation among scientists in the developed and developing countries is that both are familiar with and utilize similar health research equipment. This should be taken into account in efforts to strengthen institutions and plans made should guarantee that similar technological means are made available for use by the centres cooperating with each other.

## 2.2 Concentration on three priority areas of investigation

The broad outline of priorities contained in the first report of the Scientific Planning Group<sup>1</sup> served as a useful background for this meeting's determination to select a small number of topics for immediate attention and action. Three such topics were selected, each exemplifying a priority problem and an approach: first, adaptation to rapid sociotechnical change; secondly, alcohol problems with special reference to research on preventive intervention in adolescence; and thirdly, the promotion of child and family health through application of biobehavioural principles in primary health care.

The first of these themes deals with a broad contextual issue which needs to be examined in order to promote health; the second with a specific behavioural style likely to cause major health and economic losses and with ways of modifying it; and the third with a specific health service issue which could also benefit from results of an expanded programme on biobehavioural science and mental health.

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<sup>1</sup> Implementation of recommendations made by ACMR at its twenty-second session: Mental health. Report of the first meeting of the Scientific Planning Group on Research and Research Training in Mental Health, Geneva, 27-29 August 1981 (ACMR23/81.9).

### 2.2.1 Adaptation to rapid sociotechnical change

The human species is intensely social. This fact is so much a part of daily life that it is easy to overlook its significance in human adaptation. People everywhere are organized into societies. They repeatedly must choose between serving individual interests and those of the group.

In modern times, the fundamental human propensity for attachment is expressed in a largely unprecedented sociotechnical context. In advanced industrial societies, especially those characterized by high geographic mobility, the family is often so scattered that relations among its members are changed and attenuated. The (nuclear) family is no longer the basic unit of production. The mass media enter intimately into family life. Schools have taken over some family responsibilities for preparing the young for future adaptation. The emergence of large social units engendered by the needs of industrial production and made possible by advances in technology of communication and transport paradoxically decreases opportunities for close human relationships and makes it difficult to sustain the unity of purpose of small groups and the sense of community.

Many changes that have occurred in society are positively valued by the participants. People move in search of economic, social, and environmental opportunities. Modern communities, particularly in rich countries, provide many facilities and choices for those with good health and economic circumstances. In some cultures, privacy and independence are valued along with attachment and a sense of belonging. In many settings family ties are built more on common interests and mutual attraction than in earlier times, when social and economic circumstances offered people few choices. Though non-family relations have become exceedingly important in recent times, family relations and those of its traditional functions that remain (e.g., maintenance of life-long ties and child rearing) are still a significant element of the social support networks that are conducive to health.

The role of social support networks in mediating the effects of stress is currently a matter of growing interest, both in promoting health and in responding to illness. Disruption of social ties and community contexts is a highly stressful experience for many people. Such disruption can occur for both positive and negative reasons. These include moves to a new job, community, or school; loss of spouse; impaired health; loss of income or employment; forced migration; natural disaster and wars.

Support systems are attachments among individuals that tend to promote mastery of difficult experiences by offering guidance about tasks and strategies, identifying personal and social resources, and providing feedback about behaviour that fosters improved competence. The cumulative findings from studies in this area strongly suggest that social support can foster health and promote recovery from illness over a wide range of disorders.

Many research opportunities exist for further understanding the relations among stress, illness, social support, and the utilization of medical services. One example of exceptional interest involves a recent body of research into the relationship between human attachments, illness, and mortality. It is providing a growing amount of evidence that people whose human attachments are weak also are more prone to illness and early death. Although mechanisms of such vulnerability are not yet firmly established, it appears that support systems can buffer stressful experiences. Such networks also can influence the use of health services and the adherence to medical regimens. This is pertinent to the requirements for behaviour change such as smoking cessation or sanitation practices. Social support systems facilitate the development of coping strategies that help people contain distress within tolerable limits, maintain self-esteem, preserve interpersonal relationships, meet requirements of new situations, and prepare for the future.

Another strategy which could be used to learn about the coping needs, and factors which affect them, is stress research - an area where health and behaviour relationships were first studied in a systematic way. An impressive body of knowledge has been accumulated in this area over the past several decades. This can now be applied to a variety of human experiences such as work, family disruption and major life transitions. Basic research has provided



knowledge about human adaptability and tolerance limits, which can be used in shaping work conditions and in directing technological advances in such a way that stress related to work or other demands can be kept within tolerable limits.

Study of stress at work may be of particular interest because it is strongly related to the introduction of new technology. The work environment is the site of the most dramatic transitions brought about by technological advances. The benefits of technological advances in terms of increased productivity and reduction of physically dangerous jobs are well recognized. At the same time, increased mechanization and automation causes negative multiple physical and mental side effects which can probably be avoided if sufficient attention is paid to the psychological needs of those working.

### 2.2.2 Alcohol problems, with special reference to research on preventive interventions in adolescence

Alcohol-related problems constitute one of the heaviest burdens of illness in the world today. Mortality rates are higher for those who drink heavily than for those drinking little or abstaining. A number of physical disorders (e.g., cirrhosis of the liver) are directly linked to alcohol consumption. Alcohol abuse also contributes to many accidents, suicides and homicides.

Pregnant women are at special risk for problems related to alcohol. Heavy drinkers are more likely to deliver babies who have the foetal alcohol syndrome - characterized by certain physical abnormalities and often associated with mental retardation. There are reports of lowered viability at birth, poor sucking ability, heart rate abnormalities, and various other behaviours associated with poor functioning of the central nervous system even of women drinking moderately during pregnancy.

Alcohol abuse and related problems have biological, psychological and social dimensions. It is still unclear exactly which of alcohol's many effects is responsible for alcohol dependence. Among promising lines of inquiry are studies of the acute and chronic effects of alcohol and its metabolites on cell membrane fluidity and neuroregulatory function. Animal and human evidence for a genetic contribution affirm the value of a continued search for specific genes that place an individual at higher risk of alcohol dependence. In conjunction with psychological and social approaches, basic physiological research may suggest ways to identify people at high risk of becoming dependent on alcohol.

Relationships among alcohol problems, the stress of life events, social supports, and various styles of coping are rich areas of research opportunity. The impact of alcohol abuse on family life is also a topic deserving special attention. Interest in research on alcohol-related problems among the elderly also is growing. The influence of social forces such as work settings is another important research focus. Furthermore, factors affecting remission merit more attention; new research should provide a better understanding of how to design effective and appropriately targeted prevention and therapy programmes.

Most alcohol initiation now occurs among early adolescents and to a lesser extent young adults. Because the habit is so difficult to give up, it is vital to determine why these young people start drinking alcoholic beverages and what methods would be most effective in helping them not to do so. To date, successful programmes have in common the active involvement of young people in developing strategies to cope with pressures from peers, media and adults.

Since adolescents typically engage in high-risk exploratory behaviour, this neglected phase of the life span urgently needs research orientated to prevention of health-damaging behaviour. Research in this area can usefully draw from the wider background of a WHO-coordinated programme of research and action which deals with community responses to alcohol problems, development of treatment and management techniques, socioeconomic analysis of alcohol consumption and the investigation of alcohol problems at work and in families. New findings would not only help in stemming the alcohol abuse epidemic but could provide clues about the prevention of other untoward health effects of adolescent risk-taking behaviour.

2.2.3 Psychosocial aspects of primary health care, with special reference to the promotion of child and family health (including community diagnosis, preventive interventions, and childhood epilepsy)

Research is needed to formulate strategies for the incorporation of psychosocial information into general health services, particularly in the context of primary health care and its components dealing with child and family health, nutrition, environmental sanitation and family planning.

The need for such an incorporation of knowledge has been clearly recognized by WHO governing and advisory bodies (including the ACMR) in the past. The Group therefore decided to give attention to approaches which could be used in this work rather than to restate the arguments for the priority which should be given to this area of work.

An approach that would provide information needed to plan services as well as new knowledge would be to foster epidemiological work and to encourage the use of identical methods so that valid international comparisons can be made. There would be great interest and public health relevance in national studies comparing rates of childhood or family problems in areas of relative stability and other areas in which there is a major social disorganization (e.g., slum areas, areas with high migration). This would enable planners to examine the degree of impact of such disorganization on child development, health and welfare. There would also be value in examining type of family structure (nuclear, extended, broken nuclear, extended in transition to nuclear, etc.) in relation to rates of disorder.

Another approach - and an area of investigation of particular importance - is that of assessment of efficacy of health promotive activities at the primary care level. This is a vast and ill-defined area, ranging from the impact of doctor-patient relationship on disease outcomes to the motivation of health staff to work on socially relevant issues. Of importance at all levels of health care, these issues are crucial at primary care level and knowledge which would allow rational action is far too limited. A concerted effort by WHO might well provide the impetus which would orient the interest of the scientific community to these sorely neglected issues.

Research directed to the determination of effectiveness of psychosocial interventions in pregnancy (e.g., on effects of work with groups of mothers on the duration of breast-feeding and on length of birth interval) appeared to the Group to be a particularly promising approach since its results could be utilized in the implementation of priority measures to promote health and because of the possibility to extrapolate from such findings.

Another approach is to study ways in which epilepsy in childhood and adolescence can be managed in the framework of primary health care. The points of particular interest would be patient compliance and the possibility to avoid the stigma attached to children suffering from this condition. Here again, new knowledge would not only help in the management of a frequent and serious disorder (often leading to disability if inappropriately handled) but also contribute to knowledge about the avoidance of stigma, compliance with treatment, and similar psychosocial issues often determinant for the success of health interventions.

3. ACTIVITIES IN 1982-1983

The Scientific Planning Group proposes to move ahead as rapidly as is consistent with prudence, careful organization and credibility for the various interested parties whose cooperation is essential for success of this venture. These parties include: (i) Member States of WHO; (ii) the world scientific community; and (iii) potential donor organizations.

Preparation involves not only initiation under favourable conditions, but also processes that will favour effective long-term maintenance of a high-quality programme. It will also be necessary to demonstrate to potential donors that this programme not only builds upon the existing work in mental health, neurology and behavioural sciences, but also goes beyond a well-established programme to enter new territory of exceptional significance and enters this territory having carefully scouted the terrain in advance. The commitment of WHO will also

have to be demonstrated. The scientific community and donor organizations will need evidence that mechanisms have been constructed to assure high-quality research over the long term, involving scientists both inside and outside WHO.

The Group recommends that in the 1982-1983 period, three activities be undertaken simultaneously: first, task forces should meet in workshops which will produce research protocols in the three priority areas (see page 6); secondly, a monograph and a series of papers about issues covered by the programme should be prepared; and thirdly, preparations should be made to establish a network of centres which will collaborate with countries and WHO in this programme.

### 3.1 Task force workshops

The Scientific Planning Group proposes that three workshops should be held in 1982-1983 on topics described on page 6. A substantial summary of discussions of each workshop would be prepared for independent publication and for inclusion in a monograph (see below). The workshops would serve to heighten awareness of decision-makers and the scientific community about these vital and neglected problems, and to specify promising lines of inquiry. Each workshop would, in addition to a report, produce a specific research protocol addressing a critical issue suitable for early inclusion in the Expanded Programme of Research and Training on Biobehavioural Sciences and Mental Health.

The preparation, conduct and follow-up of these workshops will require a full-time staff member who can help with the technical and administrative efforts and consider action beyond the workshops. Each workshop would be planned by a task force of three to four people, including two Scientific Planning Group members. The task force would also guide the write-up of the workshop's report and the research protocol.

In congruence with the priorities listed on page 6, topics proposed for the workshops are as follows:

- (a) Adaptation to rapid sociotechnical change: coping, social support networks and health.
- (b) Alcohol problems, including family stress, with special reference to prevention in adolescence.
- (c) Psychosocial aspects of primary health care with special reference to the promotion of child and family health (including community diagnosis preventive interventions and childhood epilepsy).

### 3.2 Preparing a monograph on health and behaviour in developing countries

This monograph could be constructed along the lines of a recently published book on the situation in a number of industrialized countries, entitled "Health and behaviour: frontiers of research in the biobehavioural sciences"<sup>1</sup> and its purpose would be to provide an up-to-date review of available knowledge (and its gaps) in this area.

The building blocks for the WHO monograph would include:

- (a) a set of papers already commissioned by the Scientific Planning Group (see Annex 2). Outlines of these papers were reviewed at this meeting and found to be promising. Feedback is being provided to the authors, and additional papers are being commissioned on critical issues;

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<sup>1</sup> Report of a study by the Institute of Medicine, Washington, 1982: Health and behaviour: frontiers of research in the biobehavioural sciences, edited by D. A. Hamburg, G. R. Elliott and D. L. Parron.

- (b) the workshop reports (see above);
- (c) a summary of WHO's current and past work on related issues.

Two short versions of the report might well be prepared - one for publication in an international journal such as Science or Nature, and another for a less technical, health-oriented audience. A special issue of a WHO journal could be considered for this purpose.

### 3.3 Preparations for the establishment of a network of collaborating centres

What shape might the succeeding phase take? A mechanism would be constructed to carry out major programmes of research on two or three critical problem areas. Institutionally, a logical next step would be to establish at least three novel mental health and biobehavioural research centres in developing countries: perhaps one in Africa, one in Asia and one in Latin America. Spearheading the effort, these should develop their agendas naturally from the outcome of the three workshops, using experience obtained in the conduct of the mental health and other programmes of the Organization. These centres might well be linked - at least in a consultative way - with cooperating centres in technically advanced countries.

The initial collaborating centres would be selected by an explicitly designated group involving staff and scientific consultants. Site visits would be necessary and the criteria for selection of centres might include the following:

- (a) Existing interest and experience in research (of any type).
- (b) A climate of respect for research in the government.
- (c) At least a modicum of dependable core support for the existing research unit within its institution.
- (d) The commitment of country authorities to the continuity of the programme and the centre.
- (e) A catchment area available for work of the centre.

It would be very difficult to set up an effective network unless scientists and other personnel at the centres share not only common purposes and interests, but also a reasonable amount of knowledge and skills. Any effort to reduce the technological gap by facilitating the flow of information and the transfer of technology - in addition to actual access to all forms of health technology - would depend on good cooperation between centres in the industrial and developing countries.

Very often in the developing countries, the fact that a centre has attained visibility and international recognition is taken ipso-facto as a sign that it enjoys sufficient resources coming from "foreign" sponsors. Government and academic institutions tend to share this view and are reluctant to accept their responsibility of contributing to the support of such centres. This sometimes jeopardizes the entire enterprise - or at least the long-term fulfilment of its promise. Such centres tend to have well-defined programmes and a weak infrastructure. For long-term success, a clear recognition of shared responsibility and division of labour among supporting institutions would be most helpful.

In terms of technology, one of the most inefficient aspects of multicentre operations at present seems to be the handling of data processing and analysis which is done through remittance of transcribed data by mail to the headquarters of a study, a burdensome and unpredictable procedure. There is an urgent need for devising a system which would allow for processing and analysis of data at the centres and transfer of results to a central office.

Budgetary support for each centre would assume support from non-WHO sources. However, it would be useful for WHO to provide a modest increment of regular budget core support for new activities.

In addition to conducting research, a primary function of each centre - and of the network as a whole - would be to stimulate promising young research workers and provide them with additional research training in whatever mode is necessary.

The coordination of the network would include:

- (a) annual meeting of network leaders, the breadth of participation depending on the availability of funds (this meeting might well be in Geneva, but it could be held at one of the centres - especially if the research workers wanted to do so for a scientific purpose);
- (b) fostering year-round communication exchange of information and of documentation and training tools;
- (c) regular exchanges of staff.

Coordination of support for these functions would require at least one WHO staff member in Geneva, on a half-time basis.

#### 3.4 Budget estimates

The budget for the work described in this chapter would ideally be provided by the Director-General for the purpose of launching the special programme. If this were to prove impossible, a planning grant could be requested from a foundation or other agency, but this would cause regrettable delay.

The budget for the succeeding phase can be estimated more accurately when the exact shape of the effort emerges from the workshops, the work on the preparation of the monograph and other activities undertaken at present. The Scientific Planning Group could help in this process by the conduct of workshops and the selection of centres and should therefore be kept for another year.

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ANNEX 2

COMMISSIONED PAPERS

- Definitions of health and consequences for research
- Community-based prevention research with implications for developing countries
- Sociology of health care in developing countries
- Community neurology
- Social aspects of health: a research agenda
- Mental health problems in general health care
- Epidemiology of psychosocial and mental disorder in communities and health services
- Size and nature of burden of behaviour-related illness
- Effects of extreme environments on health
- Behavioural problems in water use

## BACKGROUND PAPERS

- Report of the first session of the ACMR Subcommittee on Mental Health and Neuropsychiatry, Washington, 26-28 June 1980 - ACMR22/80.12
- Report of the first meeting of the Scientific Planning Group on Research and Research Training in Mental Health, Geneva, 27-29 August 1981 - ACMR23/81.9
- ACMR Report on its twenty-third session, Geneva, 12-15 October 1981 - ACMR23/81.12
- Progress Report on Biomedical and Health Services Research prepared for the Thirty-fifth World Health Assembly - A35/5
- Report on Research and Technology Development in the WHO Mental Health Programme - MNH/80.16 (Rev. 1)
- Social Dimensions of Mental Health - WHO paper, Geneva 1981
- Report of the fourth meeting of the Coordinating Group for the Mental Health Programme, New Delhi, 22-28 October 1981 - MNH/82.4
- WHO Medium-Term Mental Health Programme 1975-1982 - WHO/MNH/78.1
- Research and Research Career Structures in Africa and Eastern Mediterranean Regions - ACMR22/80.14, Annex 1
- Extracts from reports by regional ACMRs
- Report of the nineteenth meeting of the Pan American Health Organization ACMR, Costa Rica, 9-13 June 1980, "Malnutrition, mental development, behaviour and learning" - HRC 19/1
- Report of the twentieth meeting of the Pan American Health Organization ACMR, Washington, 8-11 June 1981, "Social science health research" and "Mental health" - HRC/20
- Report on the Scientific Working Group Meeting on Mental Health Research, Karachi, 6-9 June 1981 - EM/MENT/99, EM/RSR/17, SM/SCF.WGR.MTG.MHR/17
- Report of the EM Advisory Committee on Biomedical Research, sixth meeting, Islamabad, 14-17 September 1981 - EM/6TH.MTG.ACMR/11
- Report of the EM Advisory Committee on Biomedical Research, fifth meeting, Nicosia, 10-12 September 1980, "Research in the Regional Programme of Mental Health" - EM/5TH.MTG.ACMR/17
- Report of the sixth session of the European ACMR, Copenhagen, 16-18 September 1980 - ICP/RPD 001(6)
- Report of the seventh session of the European ACMR, Copenhagen, 15-17 June 1981 - ICP/RPD 001 (7)
- Note of the eighth meeting of South-East Asia ACMR, 25-28 May 1982, on Behavioural Science Research
- Report of the fifth session of the Western Pacific ACMR, Manila, Philippines, 14-16 April 1980 - WPR/ACMR/80.20
- Report of the sixth session of the Western Pacific ACMR, Manila, Philippines, 28-30 April 1981 - WPR/ACMR/81.16