

A history of the WHO Advisory Committee on Health Research

By Dr Pierre Mansourian

As WHO's Advisory Committee on Health Research (ACHR) celebrates its 50th birthday, it seems only natural to reflect on the past. For this reason, WHO's former Director of the Office of Research Policy and Strategy Coordination, Dr Pierre Mansourian, has compiled a history of the ACHR. The history brings together facts and figures from WHO's early days, source materials that illustrate the directions that the ACHR has taken, and Dr Mansourian's analysis of developments as seen from his unique perspective. The material compiled by Dr Mansourian, which covers the first four decades of the ACHR's existence, has still to be edited and laid out for publication. Nevertheless, it is hoped that this summary will give ACHR members a feel for the historical overview that Dr Mansourian has prepared and a brief glimpse of some of the issues that have been faced by the committee to which they belong.

WHO's concern for health research started before the ACHR was founded. The historical overview takes us back to the International Health Conference of 1946 which placed promoting and conducting research firmly in WHO's constitution, and to the 2nd World Health Assembly of 1949 which described "research and the coordination of research" as an essential function of the Organization. While resolution WHA2.19 of that Assembly still represents WHO's basic policy on health research, the history provides references to all other resolutions, meetings, statements and major WHO publications that have given further focus to that policy over the years.

While plans for a World Health Research Centre in the early 1950s came to nothing, there was considerable pressure to make the significance of research more overt in WHO's organizational structure. In 1959, of course, the Advisory Committee on Medical Research (ACMR) – the name given to the ACHR in its early years – was founded and given the role of directly advising WHO's Director-General on research issues. From then on the committee (whether called ACMR up to 1986, or ACHR afterwards) played a vital role as the guardian of WHO's original research principles, the driving force behind many of WHO's research activities, and the inspiration for the Organization's research policies.

It is impressive today to see that during the 1960s various World Health Assemblies adopted as many as 15 resolutions relating to medical research. In the later years of that decade, however, with research-focused resolutions on health and economic development (1967) and the human environment (1969) it became clearer that the term "medical" was already too limited for the research role of WHO – and of its advisory committee. In 1965, the role of research earned greater recognition when the International Agency for Research on Cancer (IARC) was established under the auspices of WHO.

The 1960s were a period of consolidation for the advisory committee. The 1970s, however, are described in terms of expansion. This is hardly surprising. The 1970s saw the creation of regional ACMRs, with purposes similar to those of the global committee but with a regional focus, and reports from those regional advisory committees – summarizing their research activities over the years – will be included as annexes to Dr Mansourian's history. The 1970s were also the decade

when special programmes on aspects of health research were created (HRP on human reproduction research in 1972, and TDR on tropical diseases research in 1975). The establishment of TDR followed a formal recommendation from the ACMR which also affirmed the need for a minimum funding level for the programme. Long before partnerships for health became fashionable, the ACMR was clear that the special programme was a model for the future.

The emphasis on research that emerged with the creation of IARC, HRP and TDR, was perhaps not as strong as might be imagined. Dr Mansourian points out that in 1976 – the year after TDR was established – less than 4% of WHO's regular budget, about US\$ 5 million, was estimated to be allocated to research. In the mid-1970s the advisory committee pointed out that most of WHO's research activities were being carried out within the disease programmes of the Organization but "not as part of an Organization-wide programme of research coordinated and funded through an identifiable framework and plan". During the same period the ACMR also expressed concern that not all health research was of the same standard, and some was definitely considered "poor". The ACMR also led the way in questioning whether the research priorities of the day really reflected health needs.

In the late 1970s, two events took place that were to have considerable impact on WHO's research agenda. First, the International Conference on Primary Health Care, which was held in Alma Ata (USSR) in September 1978, stated that primary health care "is based on the application of the relevant results of social, biomedical and health services research and public health experience". This represented a clear call for a broader role for the ACMR.

Second, the United Nations Conference on Science and Technology for Development, which took place in Vienna in August 1979, stressed the need for the benefits of science and technology to be shared equitably by all peoples and for more research to be conducted on and by developing countries. For the ACMR, this meant an even stronger focus than before on promoting research by developing-country researchers. It also led the advisory committee to set up a subcommittee to look specifically at ways to enhance the transfer of health technology to developing countries. That subcommittee also investigated potential "appropriate technologies" for low-resource countries.

In view of the broadening of the terms of reference of "medical" research, it is not surprising that the ACMR took a closer look at WHO's "expert advisory panels" – from which a variety of expert committees, task forces, and other expert groups had been convened by WHO since the late 1940s. One issue raised in the ACMR related to just what "expertise" meant in a WHO context. As a report to the WHO Executive Board later commented, expertise in WHO cannot be confined to predominantly scientific and technical knowledge but "must extend to a wide range of public health experience, acquired in an extreme variety of social and economic settings".

When taking stock of global research needs and capabilities, the ACMR also reviewed the role of the WHO collaborating centres. The first collaborating centre appointed by WHO was an influenza centre in London in 1947. The number of centres grew over the years to several hundred and they had a variety of roles. A considerable number of these collaborating centres conducted research of various kinds for the different disease programmes of WHO. Thanks to the ACMR, the role of these centres as a global network of support for WHO was considerably enhanced.

The focus on primary health care in the 1980s meant not only more focus on basic health interventions and the development of appropriate technologies, but also led to much more emphasis on strengthening research capacity where it existed and building it where it did not. Consultations, symposia and workshops throughout the 1980s aimed to support “national self-reliance in health-related research”. The ACMR, or the ACHR as it came to be called in this decade, stressed that verifying research priorities by using reliable epidemiology was of the “greatest importance” in resource-constrained countries. WHO member states were called on to draw up national health research policies and plans of their own based on their health priorities. The need to encourage research by promoting research as a career choice was highlighted, as was the need to share scientific information (both by supplying research literature to developing countries and by furthering the publication of research from developing countries). Twenty years after its creation, HRP was spending one third of its annual budget on strengthening research capacities in developing countries.

In a historical overview of the ACHR it is difficult enough to cover all the issues that came before the members of the advisory committee, or all the statements and recommendations – not to mention warnings – that they issued. In a summary of an overview it is clearly impossible. Those covered in the history include health systems research (about which in 1986, WHO Director-General Halfdan Mahler commented, “we just are not making any significant progress in this field”) and research initiatives in epidemiology, early warning systems, geographic information systems, pattern analysis, systems analysis, and modelling and simulation techniques. At various times, advisory committee discussions also dealt with intersectoral research, behavioural research, the interpretation of health data, and – not surprisingly – the issue of how to set research priorities.

Dr Mansourian draws attention to several initiatives in “strategy formulation” by the advisory committee. In 1975, for instance, the ACMR held a round table discussion, chaired by Lord Solly Zuckerman who commented: “We would be deluding ourselves if we supposed that the more sophisticated kinds of health care which the advanced countries enjoy can be immediately and easily transported to some countries of the Third World. This consideration should be in the forefront of our minds.” In the late 1980s, the ACHR published the report of its subcommittee on health research strategy which, in the words of the subcommittee’s chairperson Professor Thomas McKeown, concluded, among other things, that “the rate of progress is most seriously restricted by the failure to identify the main determinants of health, and to establish priorities in health activities in the light of the conclusions”.

Among the concerns of the ACHR that are highlighted for the 1990s, Dr Mansourian includes career structures for research. This was a subject of discussion during the 1990 World Health Assembly and led to recommendations for strengthening the management of health research at national level and for establishing career structures. In particular, it was proposed that career structures should make provision for senior researchers to continue doing research as a career rather than having to move to positions in management or administration in order to get a promotion.

In the 1990s, the ACHR spent some time considering the interaction of economic and environmental factors with health. The advisory committee drew attention to the need for new indicators to measure socioeconomic variables that could not be directly observed or measured. A 1993 report on the “principles, perspectives and strategies” of health research referred to the need for research on

“multisectoral contributions” to health. Not only money (or the lack of it) was said to affect health, but also housing, suitable food, the quality of nutrition, industrialization, employment, environmental effects, and other factors. The ACHR pointed out that not only do many sectors affect health, but health (or the lack of it) in turn affects other sectors, and therefore the interactions should be investigated to provide a rational basis for forecasting, planning and resource allocation at national level within all sectors, including health.

Other 1990s issues covered in the historical overview include scientific advances such as DNA testing and genetics, changing perspectives of disease and disability (including the concept of disability-adjusted life years, or DALYs), and the impact on public health of the “constructed environment” with all its pollution, radiation and electromagnetic fields. The research agenda of the future, the ACHR predicted, would need to include the impact on health of both environmental changes and societal behaviour.

Dr Mansourian’s history of the ACHR ends with the close of the 20th century. By that time, the ACHR was considering the health research agenda for the third millennium. The advisory committee noted that “whereas the use of advanced technologies is providing people with new opportunities, there is an increase in starvation and misery in many countries”. It added that in spite of diversity, humanity shares a common fate, condition and ethic. In 1998, the ACHR looked at an increasingly globalizing world in which social indicators were frequently expressed in monetary terms, thus linking happiness to material welfare. It considered national data that are based on averages, and that often do not reveal pockets of poverty or poor health conditions. And in a world where the 4 million scientists and engineers were distributed in a ratio of 25 to 1 between developed and developing countries, the advisory committee looked forward to an age in which health research could be furthered through a “network of scientific networks” using new communication technologies.

The history of the ACHR in many ways mirrors that of WHO itself. The initial focus on infectious diseases, the shift of emphasis to communities and to primary health care, the strengthening of local capacity, and the challenge of achieving equity in health in a globalized world – these are all major issues that have occupied both the advisory committee and WHO itself. Just who led the way is hard to say, and of course it makes no difference now. What can be said is that WHO has always needed health research and will continue to need even more in the future. The need for a sound evidence base is increasingly recognized.

Dr Mansourian’s history of the ACHR, which shows how the advisory committee’s advice was closely linked with WHO’s actions (not always, but often), is a tribute to the many distinguished scientists who served as members of the committee over the years.

The history will be published by WHO in 2010.

Lead author: Pierre Mansourian

Contributors: LG Cuervo, T Nchinda, M Manciaux, U KoKo, Aung Than Batu, B Scoggins, M Jegathesan, A Shirai, M Afzal