

Collaborating with developing countries in psychiatric research[†]

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The World Mental Health report (Dejarlais *et al*, 1995) and the Global Burden of Disease study (Murray & Lopez, 1996) have drawn attention to the huge burden of illness and severe disability that accompanies mental illness in people living in low-income countries – the majority of the world's population.

THE NEED TO COLLABORATE

The challenges of conducting psychiatric research in the developing world are outlined by Alem & Kebede (2003, this issue). Low-income countries lack the specialists and health care workers with the knowledge to manage and conduct research into mental disorders. There is no reservoir of epidemiologists, research psychologists or social anthropologists with psychiatric expertise, and no facilities, staff or funding for their training to post-graduate level. The epidemiological expertise available tends to be taken up with the study of infectious diseases. International recruitment of health personnel (including academics) from low-income countries causes the problem of 'brain drain', with many more indigenous psychiatrists practising in Western countries than in their countries of origin. In Ghana, for example, there are 13 psychiatrists for a population of 18 million. However, there are 16 Ghanaian psychiatrists in the USA, at least 11 in Canada, 2 in Australia and 4 in the UK. The situation regarding trainees is the same, with at least 21 Ghanaian postgraduate trainees in psychiatry in the UK (details available from the authors upon request). The few health workers remaining in their countries of origin are overburdened with a huge clinical case-load, leaving little time for mental health research. Those who leave to undertake careers in Western countries

often do not return, or even take an active interest in mental health issues in their countries of origin. Thus, low-income countries do not have the personnel or expertise to undertake the essential research needed to inform policy and, politically, low priority is given to health issues in general and mental health in particular.

The result of the scarce resources and poor career opportunities is that there are very few mental health research networks or centres in the developing world (Jablensky, 1999). One way of dealing with this problem is to participate in collaborative research with Western colleagues. However, the huge burden of illness and the constraints outlined below present challenges to such collaboration.

PROBLEMS WITH COLLABORATION

Researchers in low-income countries are often under implicit or explicit pressure to conform to Western models in exchange for collaborative arrangements, acceptance by the international scientific community, participation in meetings and publications, and financial support. The lack of resources and the threat of intellectual isolation may push bright young researchers in these regions into adopting values, conceptual frames of reference and research agendas that make their work acceptable to Western colleagues. When this occurs, research questions and findings that are thought to be at variance with the dominant paradigm represented by scientific journals and conferences tend to be put aside (Jablensky, 1999).

According to Jablensky (1999), the 'top-down' approach of international programme planning has not achieved much and is unlikely to be successful in the future, even if greater international resources are made available, unless any external input (including workforce training,

diagnostic and treatment technology and health research skills) is matched by sustainable, indigenous initiatives. Another important observation is the perceived underrepresentation of the few researchers (and potential researchers) from developing countries on international panels of experts who prioritise and find solutions to problems in low-income countries.

NEW MODELS OF COLLABORATION

More innovative models with a long-term focus on capacity-building and sustainability should be adopted. These should be founded on true cooperative partnerships and based on the following four broad principles (Costello & Zumla, 2000):

- (a) mutual trust and shared decision-making
- (b) national ownership
- (c) emphasis on putting research findings into policy and practice
- (d) development of national research capacity.

Within such a framework, research agendas, mechanisms and benefits would be more transparent. A detailed checklist for evaluating the principles of research partnership in developing countries is provided by the Swiss Commission for Research Partnership with Developing Countries (1998). The World Mental Health report also provides an agenda for mental health research in low-income countries (Dejarlais *et al*, 1995). An African Health Research Forum (Appendix) was launched in Arusha, Tanzania, on 12 November 2002 (Mugambi, 2000). The idea of an African Mental Health Forum, with the same broad functions, should be actively pursued.

One example of an innovative collaborative network is the 10/66 Dementia Research Group, composed of researchers who have linked together to try to redress the imbalance in dementia research. Less than one-tenth of all population-based research into dementia has been directed towards the two-thirds or more of people with dementia who live in the developing parts of the world – hence '10/66'. Regional networks have been established in Sri Lanka and India. This group is affiliated to the Alzheimer's Disease International group and is coordinated through Dr Martin Prince, Section of Epidemiology, Institute of Psychiatry, London (<http://www.alz.co.uk/1066/html>).

[†]See pp. 185–187, this issue.

SUGGESTED ACTIVITIES WITHIN RESEARCH PARTNERSHIPS

The following activities for research collaboration are proposed:

- (a) establishing global databases and networks of researchers (trainees) from low-income countries;
- (b) conducting surveys and audits of research activity in low-income countries;
- (c) involving researchers from low-income countries in discussions and projects;
- (d) spotting and mentoring potential research leaders for developing countries;
- (e) encouraging researchers who are willing to return home and facilitating maintenance of links to prevent academic and intellectual isolation;
- (f) arranging research training locally, making use of expatriate staff as well as indigenous academics based overseas. The focus should be on injection of relevant skills by contracting into key positions qualified overseas staff with the specific mandate to train someone local to take over their position within 2 years. This would be much more cost-efficient than sending trainees overseas. Trainees would be able to formulate research questions and hypotheses relevant to their own countries.

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APPENDIX

Functions of the African Health Research Forum

The following functions are proposed (Mugambi, 2000):

- (a) articulation of the African voice on health research;
- (b) development of a health research policy framework for accelerated development;
- (c) strengthening of health research networking in the region;
- (d) provision of technical support to countries;
- (e) conduct of analytical work to support health research development;
- (f) promotion of effective collaboration with partners;
- (g) promotion of adherence and funding of local priorities;
- (h) enhancing effective research communication;
- (i) promotion of ethics in research;
- (j) development of health research leadership.

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