

Lessons from the Field

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In this issue we are introducing a new section into the *Bulletin* entitled “Lessons from the Field” (pp. 34–42). Many papers that are submitted to international journals describe pragmatic, opportunistic or creative solutions to conducting research in difficult conditions, but are rejected for methodological reasons. This contributes to a situation in which decision-making on interventions for diseases of the poor often rests on a very limited evidence base. A wealth of knowledge in the field exists and is waiting to be tapped. Much of this knowledge concerns both the differing epidemiological and cultural contexts and the different health systems that affect the delivery of interventions. Papers that use and build upon on precisely this kind of knowledge to solve public health problems will be the mainstay of the new section.

The recently published *World report on knowledge for better health* (W1) draws attention to the fact that, in addition to knowing that an intervention works, we need to have knowledge about how to implement and use the intervention effectively. The randomized control trial (RCT) is considered the gold standard for an intervention study; however, public health interventions are difficult to evaluate using this study design (either because of the nature of the intervention or because of the setting). The *Bulletin* has published many intervention studies that are not RCTs but ones in which the authors did what they could to overcome the limitations of their study design. Such studies will continue to be evaluated and published in the usual way.

An area in which the *Bulletin* will welcome papers for this new section is where researchers have tried to implement interventions in their local setting. There is no reason, for example, to assume that an intervention evaluated in a trial conducted under specific conditions in Latin America should work in Africa. The *Bulletin's* decision is based on the logic that researchers and public

health practitioners want to adapt successful interventions to improve local quality of care and processes. This “real feel” we believe will help to enhance the value of the *Bulletin*.

A large number of these studies have a “before and after” design, where the context, methods, and strategies for change are usually more important than the actual results. Readers learn more about how to design a successful intervention than about the magnitude of the positive or negative effect. The paper by Lawrence et al. (W2) in this issue of the *Bulletin*, which assesses the effects of a practically applied treatment system to the control of scabies in the Solomon Islands, is an example of such a study.

Papers that we accept for publication in “Lessons from the Field” will need to meet the usual criteria of ethical and scientific soundness (suitable for a before and after study design), survive the peer review process, contain a relevant research question that provides applicable results, and offer lessons to improve the delivery and process of public health interventions. These papers will have a structured abstract. The focus will be on the descriptions of the context, methods, strategies for change, and lessons learned: they could be similar in certain aspects to quality improvement reports (3).

Our initial objective in this section is to provide a forum for researchers who are confronted with the pragmatic constraints of implementing interventions in resource-poor countries to help others design subsequent interventions. However, we also wish to learn by doing and will consider experimenting with other formats. In this respect, we welcome suggestions from our readers on how this section could develop.

In all countries, much health-related research is not relevant to the needs of users. Its *raison d'être* is for researchers to publish their results in prestigious journals, with little concern to solve the sort of practical problems that health workers

have to confront in the field. This state of affairs also reflects the fact that the generation of health knowledge is more highly rewarded than its application; this concern was voiced at the Ministerial Summit on Health Research (W4), where the above-mentioned world report on knowledge was presented.

The summit also highlighted the need to close the know–do gap in global health. This gap can be considered to be “the inability to bridge effectively the gulf between what is known and what is done in practice, between scientific achievement and health realization” (5). The know–do gap has many facets: on the one hand there is the challenge to translate evidence into practice and science into policy-making, on the other there is the personal know–do gap that requires motivation or volition by the individual to translate awareness of health risks into changes in behaviour. In addition, there is often a resources gap (both financial and human) that impedes the implementation of knowledge even when other conditions are favourable.

We hope that this new section will develop as one path to bridge the know–do gap, as well as a forum for some of the research from developing countries that is currently not adequately represented in international literature. The closing of this know–do gap remains a fundamental challenge in international health. ■

References

(References prefixed “W” appear in the web version only, available at: <http://www.who.int/bulletin>)

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