

**Blessing Wazara, Zimbabwe****MOBILIZING THE INTELLECTUAL
CAPITAL OF DEVELOPING NATIONS**

The association existing between socioeconomic empowerment and population health status is well established in the literature. Furthermore, the application of purely medical interventions and scientifically sound research models within communities in developing nations to address health disparity issues, without engaging other related factors such as culture, education, gender equity and prevailing political environments, has been demonstrated to be ineffective. This association presents a variety of complex challenges to research or development agents and requires unprecedented levels of health expertise, business tenacity and diplomatic sophistry to resolve them.

However, many international nongovernmental organizations claim to be apolitical and thus go to great extents to avoid interfering with the domestic politics of the nations they operate within. Yet, a simple reality requires to be addressed. In order to sustain the gains achieved through the execution of brilliantly designed public health intervention programmes, a sound government policy must be firmly in place. For as much as leaders in developing countries with nationalistic proclivities may disseminate rhetoric advocating for the sovereignty of developing countries and express a reluctance to capitulate to the 'imperialistic forces' inherent within the foreign policies of developed nations, forward-looking research has the power to transcend the biases that often confound the interaction and exchanges between the developed and developing worlds.

Therefore, how can research-oriented organizations interested in implementing interventions for problems in developing countries cooperate with government institutions that may at times be corrupt and inefficient in delivering health-care services to its population? As an international homogenous entity of humanity, it is critically urgent for all of us to extinguish permanently the volatile forces of xenophobia that continue to persist in our reckoning of one another.

The solution for health inequities and research problems in developing countries is embedded in a multilateral adoption of policies which encourage transparency and rapid assimilation of evidence-based practices. As fellow citizens of an integrated global unit consisting of a dynamic mixture of developed and less developed nations, we must therefore strive to permit an open-minded disposition to be operational among us in any dialogue on development we engage ourselves in.

Given the vast series of sophisticated methodological procedures and technology now available to the global scientific community, another question demanding an answer would be how do research institutes, headquartered in the more developed world, penetrate developing countries, conduct research and stimulate a change in

health behaviour based on the interpretation of study results and scientific evidence? Science in this context might be viewed as yet another tool in the 'extensive arsenal of the developed world' to effect behavioural change in developing countries' cultures towards conformity to western ideals.

Therefore, a new platform of research partnership between more developed nations and the less economically developed countries must be defined. To begin with, it is of paramount importance for developing nations' leaders, particularly in Africa, to relinquish irreversibly this sycophantic posture they are quick to assume while grovelling before the developed world's institutes to provide permanently for them economic resources for aid and sustainable solutions for the problems faced by citizens of these nations. This new format of interaction being proposed would transfer a greater responsibility and accountability to the leaders of developing nations to take a more prominent participatory role in the strategy conception process to address health and equitable access issues in their individual countries. On the other hand, leaders of the more developed nations would be required to dispense with the overbearing positions of inherent superiority with regards to matters of advising the plethora of less developed countries as to what constitutes success in the development process.

Under such conditions, one can hypothesize that developing nations would be more likely to assimilate more evidence-based approaches in formulating health policy when their perception is that the interpretation of research results originated from within as opposed to being externally derived. Therefore, researchers and intellectual communities of developing countries would be expected to formulate disease prevention and health promotion strategies based on original abstractions of relevant applications of ideas described in the global scientific literature within the context of their nations.

Even in the current age of Trade-Related Aspects of Intellectual Property (TRIPS), it still remains impossible to patent the ethereal realm in which innovative ideas are conceived. Long gone is the era where developing nations are subservient spectators in the sphere in which novel concepts are birthed. The developing world must now make its own contributions to the global repository of knowledge and intellectual capital. The idea behind this proposed platform would be to arouse a radical consciousness in the researchers of developing nations, that the developed world does not possess an inborn capacity to monopolize the market for solutions to global health problems.

The variance in the cultural, socioeconomic and political composition between countries which constitute the 'developing world' is great. Therefore, when trying to propose solutions to equity problems faced by members that fit into this generalized reference, it is important to be cautious not to concoct strategies intended to serve as universal elixirs for developing countries' health systems.

However, it is difficult to ignore the similarities in the national health profiles expressed by many developing countries. This leads to the question whether underlying principles of poverty and unfavourable health outcomes exist that developing countries chronically adopt in their health policies? Inversely, are there such things as universal precepts of prosperity that the Organisation for Economic Co-operation

and Development (OECD) countries have implemented in their constitutions to secure these spectacular displays of favourable health outcomes in comparison to their counterparts in the developing world?

These are some of the multidimensional considerations that need to be made when discussing the issues of the expression of health status disparities between developing countries and more developed nations. Therefore, is universal access to health services the key to solving health problems of developing countries? In a resource-scarce environment, how could the financing of such a proposal occur? Even with a heavy reliance on the social demand of more developed nations to procure generous endowments of aid from richer nations, could this model be sustainable?

One possible solution for developing nations would be to go against the OECD model of the central government generally guaranteeing universal access to some form of health-care services for the citizens of that nation. Due to the general economic paucity of developing countries' governments and in many cases the technical inefficiency of their bureaucracies to deliver effective and universal access to health care, one concept would see a direct financing of the private health-care sectors of these countries. Since poorer nations are more likely than richer countries to experience a high volume of health professionals emigrating out of their countries in order to pursue more lucrative opportunities of employment in more developed countries, one possibility could see foreign donors refraining from unconditionally financing the public sectors of developing nations. This alternative would consist of setting up a grant mechanism that finances projects conducted by indigenous health-care service firms originating in the private sector.

These grants would be contingent upon a tender system in which interested firms submit proposals to a national committee chaired by an official from the aid agency, and each grant would afford the remuneration of indigenous health-care professionals at scales comparable to those in developed nations. This would introduce an incentive system that rewards health professionals who are willing to operate in impoverished regions. The idea behind this would be to minimize the urge of professionals to emigrate.

However, if this proposal did manage to deter the epidemic of external migration of health professionals, a greater challenge would still persist with regards to how residents of impoverished nations might obtain much needed resources to scale the financial barrier of health-care access. An out-of-pocket payment scheme is irrelevant in the context of communities in developing nations, since many individuals lack the means to procure basic food items, let alone health care.

This perhaps is the most complex challenge the developing world faces. How do you finance the cost of health care in the context of developing nations? Do you advocate for more donor aid? What percentage of the gross domestic product must developing nations' governments apportion towards national health-care expenditures? The answers are not easy to derive, neither are effective and universal solutions simple to conceive.

However, it is not difficult to deduce that the remedy for the myriad of health status disparities and research problems resident in the populations of poor countries does

not lie within a more generous dispensation of financial aid by richer nations. This evasive solution lurks deep within the communal psyche of researchers in developing countries, who by taking a leadership role in a delicate collaboration with other partners of the global research community conceive strategies which reflect the projection of each individual developing nation's unique vision of the expression of positive health outcomes regarding issues of status, access and equity.

Blessing Wazara was born and grew up in Zimbabwe. He graduated from St George's College, Harare, in 1998 and immediately began working as an administrative assistant for a non-profit organization. During this time he was mentored by several professionals who had extensive experience in health and human development projects. He then travelled to the United States to continue his education and graduated from York College with a Bachelor of Science Degree in Biology and General Science. He subsequently enrolled into the University of Colorado Health Sciences Center and is currently completing his Master of Science Degree in Public Health.