Letter to the Editor

Global research collaboration for priority setting in health systems in developing countries

Madam, Research in health has brought great achievements ranging from elimination of deadly diseases, such as smallpox, to doubling of overall life expectancy in most of the countries. Despite this, the health of the populations at large has been suffering from problems that are remediable with the sharing of the global scientific evidence. Unfortunately, this has not happened for most of the time in the past.

The health systems in different regions of the world have different issues to handle. Some countries are experiencing the demographic, epidemiologic and economic transitions and may take more time to converge with the developed world. The health policy in these countries is mostly unstable and heavily driven by the international agendas. The growing disparities between and within the countries have made the developing countries rely heavily on the evidence generated by the developed world. Financing health related research in the developing countries is lumped with high expectations to oblige their agendas and priorities. Therefore, the knowledge generated by research in these countries is not incorporated in the policies and practice and life goes on unchanged.

In our patient, the initial examination and normal CT findings suggested low risk of developing seizures and he was managed accordingly. However, it is a well-known fact that the initial CT scan may be normal and patients can develop parenchymal lesions over a period of time; and can fall into the category of high risk groups as in the present case. How to identify this group and anticipate the occurrence of post-traumatic seizures is still a challenge particularly in a patient who is recovering and has a normal initial CT scan.

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References
dilemma of health research priorities of the developing world. This intricate and multi-faceted inquiry can be answered only through the sharing of information and cooperation between the scientific communities.  

In this epoch of globalization and internationalization of health, where international and regional borders are fading out by virtue of international agreements and treaties, health sector in developing countries suffer the most. Moreover, the involvement of stakeholders such as economists, educationists, politicians and media personnel is pivotal to initiate a strong advocacy campaign for understanding the international health research agenda and there on investing in health systems research in our own setting. Finally, what are the priorities for health research? Who will set these priorities and who will address the question of allocating resources to the major health issues that the world is facing. In this regard, doing the precise needs assessment by involving communities at least for collecting the evidence should not to be ignored. Only the systematic and evidence based priority setting, building research capacity and understanding the specific needs of various developing countries will bring fruitful results to end the yawning disparities within and between the countries. Nevertheless, international community has a definite role to play in this scenario.

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References

Letter to the Editor

Risk Factors of Cardiovascular Disease among the Oral Contraceptive Users in Kermanshah City of Iran

Madam, The third generation OCP is the new progesterone which lowers androgenic activity. However the OCP that is used by the Iranian women contains levonorgestrel with high androgenic activity.

To determine the risk factors of cardiovascular disease among the women who used OCP in Kermanshah city of Iran, women were recruited from 12 primary health care centers across the city. The study group comprised of 360 women using combined low dose oral contraceptive (30 microgram ethinyl estradiol and 150 microgram levonorgestrel) for six or more months.

The mean duration of OCP use was 3.7 ± 0.2 years. The mean age and BMI was 31.8 ± 8 years and 25.9 ± 4.1 respectively. There were 43.3% women over 35 years. There were not any smokers. The mean systolic and diastolic blood pressure was 126 ± 11 and 80 ± 8 mmHg. The prevalence of hypertension was 17.5%. In women over 35 years, the prevalence of hypertension was 27.33%. Hyperlipidemia and coronary artery disease was found in 4.2% and 5% respectively. Other biochemical parameters are presented in Table.

<table>
<thead>
<tr>
<th>Biochemical Parameter</th>
<th>Mean (SD)</th>
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<tbody>
<tr>
<td>FBS (mg/dl)</td>
<td>94± 2.5</td>
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<tr>
<td>Cholesterol (mg/dl)</td>
<td>193± 1.6</td>
</tr>
<tr>
<td>Triglyceride (mg/dl)</td>
<td>187± 3.5</td>
</tr>
<tr>
<td>LDL (mg/dl)</td>
<td>117± 1.6</td>
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<tr>
<td>HDL (mg/dl)</td>
<td>39.3± 0.3</td>
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In our study the systolic and diastolic blood pressures were high. Graff and coworkers reported similar results. The OCP used by Iranian women contains 50-microgram ethinyl estradiol and 150 microgram levonorgestrel. The high dosage of levonorgestrel in these pills has high androgenic activity. This may explain why we did not observe the useful estrogen effects on lipid metabolism among the OCP users in our study.

Another main finding was high proportion of women over 35 years old among the OCP users who were hyperlipidaemic and/or hypertensive.