



**World Health
Organization**



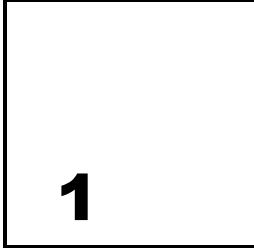
CCGHR CCRSM
Canadian Coalition for
Global Health Research Coalition canadienne pour la
recherche en santé mondiale

**WHO-Canada Dialogue on
Global Health Research –
What Did We Say?**

Key Themes from the Dialogue
November 3 & 4, 2005

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Introduction

This is the first part of a two-part report on the WHO-Canada Dialogue on Global Health Research, held at the Delta Ottawa on November 3-4, 2005.

This Part 1 document – What Did We Say? Key Themes from the Dialogue – captures in summary form the key themes emerging from our dialogue and the specific challenges put to the group in the course of conversation

A separate Part 2 document – What's Next? Refining Action Recommendations – continues the dialogue by outlining the action recommendations put forward by the working groups. It will serve as a mechanism to ask participants to reflect on the ideas generated at the session and in follow-up discussions, and provide further input which will help us focus and flesh out an action plan

We have to ask ourselves what we have done and what we are going to do with it. We all have unleashed a monster...

Francisco Becerra, referring to the Mexico Summit in his opening remarks to the WHO-Canada Dialogue

This dialogue was sparked by a sense of convergence between the goals articulated at the Ministerial Summit held in Mexico one year ago and Canadian interest, expertise, and increasing momentum. It was designed to focus on two of the resolutions adopted by the World Health Assembly, assessing Canadian capacity to contribute in each area, and generating specific recommendations for action related to these themes:

- Establish a substantive programme to support health policy and systems research (HPSR)

- Strengthen mechanisms to transform research into policy and practice (closing the “know-do gap”)

2**Seizing the Opportunity**

There's a growing sense both of momentum building and a window of opportunity standing open that we risk losing if we don't move quickly. Following the Mexico Summit, we've seen growing global interest in global health research in general, in health policy and systems research, and in making research matter by putting it to work to solve pressing problems in low-and middle-income countries.

It's not a feeling you can get every day!

*Closing message of Tikki Pang's review of WHO Initiatives
Subtitled "Taming and harnessing the monster"*

From a Canadian perspective, there are encouraging signs of leadership:

- Canada had strong representation at the Mexico summit and disproportionate to our size (72 participants of which 9 were part of the official delegation)
- Canada's support of the WHA resolutions set an example for other G8 countries and played a role in getting them passed
- Prime Minister Martin has affirmed that our long-term goal should be to devote no less than 5% of R&D to knowledge-based approaches to development assistance for low- and middle-income countries (LMICs)
- Since 2001, the Global Health Research Initiative (GHRI) partners (CIDA, CIHR, Health Canada, and IDRC) have been coordinating global health research in support of health and development in LMICs. Now more than ever, there's growing recognition within development organizations such as CIDA that strong health

- systems are a fundamental underpinning of development. There is also a growing interest within organizations such as CIHR and the Canadian Health Services Research Foundation (CHSRF) in international collaboration on health policy and systems research. The GHRI is continuing to support the evolution of the Canadian Coalition for Global Health Research, which has established task groups on “Global Health Policy and Systems Research” and “Research to Action”
- Canada’s International Policy Statement for the first time recognizes health as a central part of our foreign policy and strengthening health systems as an important part of our development policy. Health Canada is now working more closely with CIDA and Foreign Affairs on this front
 - Relevant new programs such as Teasdale-Corti* (developed by the GHRI) and the proposed IDRC/CHSRF PEARL* initiative (the latter a direct result of the Mexico Summit) are being created and championed by Canadian organizations
 - Two of the “Knowledge Networks” established through the Commission on Social Determinants of Health are based in Canada (one on child health at University of British Columbia; one on globalization at University of Ottawa), and a third (on health systems) is being supported by IDRC. Canada seems to be developing a “niche” of expertise in some of the social determinants of health, building on our reputation in advancing these concepts
 - Some members of the National Alliance of Provincial Health Research Groups (NAPHRO) are beginning to develop international collaborative relationships, and Alberta has created a program to train health managers in research technology, which might have the potential to be adapted to LMICs. NAPHRO is seeking to get better linked with other organizations interested in global health research and health policy and systems research, to share information and work collaboratively
 - Our WHO colleagues tell us the very fact that vehicles like this meeting and the partnerships mentioned above exist in Canada – vehicles for researchers, research users, and development agencies to dialogue and collaborate – gives our voice legitimacy. We have a degree of coordination which combines diversity and variety of perspectives with collegiality and a cooperative spirit

At the same time, there is a sense of missed opportunity:

- Among civil society organizations, there was an expectation that 2005 could be a moment for course correction, as countries assessed five years of progress against the Millennium Development Goals (MDGs). While there was extensive production of

* Throughout this document, an asterisk beside an initiative mentioned here indicates that there is more specific information available about it on the Coalition website at www.ccghr.ca

studies, reports, assessments and roadmaps, there has been no great leap forward in follow-up

- Unlike many other countries, Canada has not published an accountability report on our contribution toward the MDGs
- While we're increasing spending on aid, the increases will merely take us back to the investment levels of 15 years ago, before we started cutting aid budgets. The Government of Canada has not officially committed to reaching aid spending levels of 0.7% of GDP

As we plan our action, we must be mindful of how we seize this window of opportunity and keep the momentum building.

**3**

Defining Key Terms

We reminded ourselves that it's important in a dialogue like this to be sure we're aligned around what we mean by some key terms:

Health Systems and Policy

We're using this term in its broadest sense to mean all aspects of health care systems and public health systems. We're looking at issues ranging from social determinants of health to data for decision-making to health human resources. We recognize the need for multi-disciplinary approaches that include civil society organizations active in the health field, social science research organizations such as SSHRC, as well as veterinarians, agriculturalists, activists, journalists, environmentalists, sociologists, political scientists, and historians. We look to precedents like the Global Treatment Action Group – a great example of intense collaboration among Canadian NGOs, churches, labour groups, and researchers to promote legislation making generic drugs available to people with HIV/AIDS in LMICs.

Users of Health Research

Users of health research encompass policy-makers and health system managers, health professionals, civil society organizations/NGOs and front-line people doing program implementation who – whether they recognize it or not – are constantly asking research questions (“I wonder why...? I wonder if....?”).

Health Researchers

Not all health research is done in universities. We must also capitalize on the broad spectrum of research expertise in “think tank” and other not-for-profit organizations, and remember that a significant amount of operational and evaluative research is built into in-the-field development programs (although it may not be explicitly labelled as such).

Closing the “Know-Do Gap”

We’re taking a balanced approach to this task that looks at how researchers can better serve the system and how the system can better serve researchers. We don’t see knowledge as a “product” that gets inserted into an event called decision-making. We see instead two interconnected processes that need to come together – so that all people involved understand each other, know how to collaborate, and are able to support research that matters. We’re seeking to redress the existing imbalance that has the vast majority of research defined by and written for researchers. We want to shift the emphasis from “health research” to “research for health” – research that is user-driven, accessible, and packaged for use in policy- and decision-making. We need to invest in strengthening the capacity of users to meaningfully engage in the research process and make evidence-informed decisions through initiatives such as PEARL. These complementary approaches will contribute to bridging the know-do gap. At the same time, we recognize the value of investigator-driven research that asks questions a health manager or policymaker might never think or want or know how to ask (particularly potentially sensitive or political issues).

4

Exploring Opportunities

Gentlemen, we're out of money – we'll have to think.

- Attributed to Ernest Rutherford

To focus our thinking about where to invest time and money for maximum impact, we spent some time on creating a shared view of opportunities that already exist:

Build On and Learn From Existing LMIC Capacity

Mexico has already created and is implementing an extensive **Health Research Action Plan*** focusing on pertinence, excellence, accountability, and sustainability for development. EVIPNet (Evidence-informed Policy Networks) was launched this year to strengthen research to policy linkages in the Western Pacific region, and there are plans to extend the concept to Africa in 2006. With the **REACH (Regional East African Community Health)-Policy Initiative***, three African countries are taking the lead on designing a mechanism to access, synthesise, package, and communicate evidence to inform health policy and research agendas. Canada can support these efforts with bilateral funding, sharing of our expertise in collaborative research and tools such as IDRC's tools for middle managers on how to use research, collaborative training on how to translate research for managers, assistance with evaluation to ensure learning gets captured and widely shared.

Expand Existing Canadian Initiatives

We discussed this from two perspectives:

- **Making Research Matter:** The Team Grants component of what is ultimately envisioned as a multi-faceted **Teasdale-Corti Global Health Research Partnership Program*** (developed by the GHRI) has just been launched with \$10M initial funding from IDRC and CIHR, offering grants of up to \$1.6M over four years in four global health research thematic areas, of which one is HSPR. It is anticipated that the demand will greatly exceed the available funding, and demonstrate to other potential funders (including the large American foundations) the needs and benefits. Teasdale-Corti focuses on the supply side, strengthening institutions – particularly institutions in LMICs – to develop and undertake multi-year programs of research and capacity strengthening to respond to pressing health challenges in LMICs.
- **Increasing Capacity to Use Research for Decision-Making: PEARL (Promoting Evidence-based Action from Research for Leadership)*** has been designed (jointly by CHSRF and IDRC) as a complementary initiative that works with organizations to create the motivation, skills, structures, processes, and mechanisms that will make them more informed demanders and users of research. It is currently a “concept waiting for money.”

Support Existing Multilateral Initiatives: Networks and Partnerships

The WHO is championing the evolution of the **Alliance for Health Policy and Systems Research** into the **Partnership Programme for Health Systems Research**, with ownership eventually being taken by LMICs. The intent is to put the spotlight on knowledge users, strengthen LMIC capacity to conduct and communicate HPSR, stimulate debate and active dialogue, support cutting-edge research and leverage funds for HPSR, and encourage development of HPSR methods.

Champion Low-Cost/Big Impact Change

We need to be on the watch for opportunities to champion changes that may come with little or no cost, but have the potential for big impact. Within the institutions that fund and/or do research, for example, we can think about how to shift a culture that tends to think of health systems research as “not real science” and nurture a cadre of researchers who do and are rewarded for this type of work. We can train researchers to engage in knowledge translation and reward them for it, not just for knowledge creation. We can root out unfriendly policies.

We can change language in proposal calls to make them more encompassing – recognizing that until there’s a level playing field for health systems research in relation to the regular granting mechanisms, this type of research will always be marginalized. We can encourage Canadian researchers to engage globally by writing into the evaluation criteria for both research and training that we will award bonus points to proposals that demonstrate collaboration with LMIC researchers and users of research. We can promote

the trend toward “merit reviews” rather than traditional peer reviews – toward reviews that involve community members in a meaningful way, assess relevance and pertinence in addition to scientific merit, and examine what’s built into the proposal about packaging the knowledge for use by others.

**5****Assessing Canadian Capacity**

We believe that Canada has strong experience and expertise that is directly relevant to the themes being discussed – not just research expertise, but also training, engagement in civil society, consultative processes, knowledge synthesis and systematic reviews, alternate methodologies for summarizing evidence, programs to support knowledge exchange and research use, and technologically enhanced knowledge translation approaches (telehealth). Our diverse population gives us multilingual capacity.

At the same time we acknowledge a weakness in not sufficiently applying this expertise to address problems in our own indigenous and other marginalized communities. This is an example of an area where we can benefit from partnering with and learning from other countries addressing similar issues.

Canadian expertise exists in individuals within many organizations scattered across the country. We don't have a complete, up-to-date inventory of capacity in HPSR or knowledge translation – who is working in the field, who is studying in the field, who has relevant expertise that could be applied to it, who has untapped capacity.

The idea of investing in an inventory of Canadian capacity in these areas was discussed by both groups. It was recognized that to be useful, such an inventory would have to be accessible, searchable, real-time/self-renewing, focused, and validated. It would be easy to spend considerable time and money documenting capacity and keeping databases current, with questionable return on investment. Suggestions on the table for using existing mechanisms to get a better sense of capacity include adapting the common on-line CV to build a searchable database for this purpose, capitalizing on the Alliance for Health Policy and Systems Research's access to the ISI database and search algorithms, using existing networks such as the Canadian Coalition for Global Health Research and its specialized task groups to build understanding of what capacity resides where.

6

Challenging Ourselves

Throughout the day, individuals framed a number of key questions that are summarized here as challenges to the group:

- How do we best seize this brief window of opportunity and influence the Government of Canada to increase aid funding and take action on global health research? One proposal: Move the additional spending committed in bill C-48 into the base allocation, pledge a 15% annual increase, and hold the government to the Prime Minister's pledge of no less than 5% of R&D to knowledge-based approaches to development assistance for LMICs
- There are times when we can add value to existing initiatives by complementing and collaborating. There are times when we just need to get out of the way, provide the financing to support an LMIC-led initiative, and learn from what happens. Are we prepared to recognize and act on this reality?
- How do we get better at finding the political "hook" – the link to what decision-makers and the public feel to be important – that will get our proposals profile, attention, and funding? How can we make sure that policy change actually leads to new action? How do we and our partners cut through the red tape and regulations that often get in the way of the right knowledge getting produced, transferred, and translated into action?
- Should we be funding core support to universities in LMICs in the area of health policy and systems research? Most of the groups doing this are very small and reliant on piecemeal funding. Should we be thinking about the need for parallel investment in longer-term funding of the infrastructure necessary to a sustained research effort (e.g. research administration and management)?

- Should we be promoting increased research investment (money, human resources, facilities) from the health system itself to support health system research and development? Companies like IBM understand that they have a responsibility to do their own R&D – not leave it to the universities – but that’s not a widespread concept in the health system.
- Can we help WHO become a more proactive knowledge broker – linking capacity to needs across the globe – and make better use of the capacity in the WHO-designated collaborating centres?
- Can we find the right balance between systems thinking and focus? Can we, for example, pick a question and focus resources on doing something about it quickly – a question like: “What would an effective, affordable, 21st century health system for sub-Saharan Africa look like?”
- To date, donor experience in supporting health systems has met with limited success. We don’t have a solid understanding of what works and doesn’t work, but there are burning questions that need to be addressed and we can’t wait until we do. How do we build the boat and sail it at the same time? What adaptive approaches, action learning, risk mitigation strategies will allow us to do that?

Our working sessions generated a long list of initial ideas as to how we might address these challenges. Over the next several weeks, we are embarking on a process of refining, packaging, and prioritizing these ideas into an integrated Action Plan that will move us forward on both themes explored in this dialogue. That process is outlined in the companion document **What’s Next? Refining Action Recommendations** now being circulated to participants. In parallel, individuals and organizations continue to move forward with initiatives that are relevant to these challenges – some on new ideas sparked by this exchange, some on action already planned that can now be better positioned within the broader context and linked with related work.

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