For better decision making

Policymakers, Researchers and Citizens learning and working together to improve policy making

Policy briefs offering policy options informed by research results

National deliberative forums to contextualize policies

Monitoring and evaluation to improve research-to-policy methods

www.evipnet.org
Using evidence and innovation to strengthen policy and practice

‘Stronger emphasis should be placed on translating knowledge into action to improve public health by bridging the gap between what is known and what is actually being done.’  

WHO World Report on Knowledge for Better Health

Knowledge derived from research and experience is of little value unless it is put into practice, and its success monitored and regularly evaluated. Closing the gap between what we know will work to improve health and what is put into practice around the world could save millions of lives over the coming decade. This requires a better understanding of how to promote the uptake and implementation of interventions and policies already shown to be effective.143 We will make sure that our research funding includes support for work in this area and will use the forums above to share best practice. We will continue to make independent advice from our scientific advisory committees publicly accessible, in line with the Code of Practice for Scientific Advisory Committees by the Government Office for Science.144 If policy makers are going to use the findings of research, they must be closely involved in owning the work from the onset. Following this principle, we will work with others to develop capability for policy makers to engage in this process effectively. WHO’s Evidence Informed Policy Network (EVIPNet) is an example of an important initiative in this area (see Box 21).

Box 21: WHO Evidence Informed Policy Network

‘EVIPNet is an innovative initiative to promote the systematic use of health research evidence in policy making. Focusing on low- and middle-income countries, EVIPNet promotes partnerships at the country level between policy makers, researchers and civil society in order to facilitate both policy development and policy implementation through the use of the best scientific evidence available.

‘Low- and middle-income countries have scarce resources to address their health system challenges and need high-quality evidence to use those resources efficiently. Scientific evidence is a fundamental building block to improve the public health situation. If health sector managers and policy makers ignore evidence on the root causes of problems or what works best to address these problems, they risk wasting precious resources on inadequately designed programmes and policies. The direct consequence of ignoring this evidence is poor health for the population.’

WHO Evidence Informed Policy Network website (www.who.int/rpc/evipnet/en)

143 Sanders D and Haines A. Implementation research is needed to achieve international health goals. PLoS Med 2006; 3(6): e186. 
144 The Code of Practice was published by the Government Office for Science in 2007 and is available at: www.dius.gov.uk/publications/file42780.pdf.
angiotensin-converting-enzyme inhibitors should remain the preferred renin-active agent to prevent vascular events in patients with or at high risk for cardiovascular disease.

*Toni L Ripley, Donald Harrison
University of Oklahoma College of Pharmacy, Oklahoma City, OK 73190, USA
toni-ripley@ouhsc.edu

We declare that we have no conflict of interest.


EVIPNet Americas: informing policies with evidence

Public-health and health-system policies based on sound scientific evidence and best practices can improve health and equity, and the use of research results is essential for health and development.1–3 Yet accessing and incorporating research evidence to inform decision making does not occur systematically, but is especially critical in low-income and middle-income countries that face tremendous health challenges with insufficient resources. WHO is actively working to address this issue. Evidence-Informed Policy Network (EVIPNet) arose from the Ministerial Summit on Health Research in Mexico City in 2004 and a resolution adopted by the 58th World Health Assembly in 2005.4–8

The goal of EVIPNet is to improve public health and reduce inequities by increasing the systematic use of and access to high-quality applicable evidence that guides the development of policies, and helps to identify and prioritise knowledge gaps that need attention. EVIPNet addresses important issues as identified by individual countries, such as maternal and child health, HIV and AIDS control, immunisation, and infectious diseases, as well as health-system challenges such as financing, distribution of health workers, and governance. EVIPNet’s framework is based on current evidence on effective strategies for knowledge dissemination that are adapted for local context.

EVIPNet has been set up in several regions. EVIPNet was started in Asia in 2005 (with teams in Laos, Malaysia, the Philippines, and Vietnam, and three teams in China), and in Africa in 2006 (with teams in Burkina Faso, Cameroon, Central African Republic, Ethiopia, Mozambique, Niger, and Zambia). Country teams are led by senior health officials from government, in partnership with representatives from national science and technology institutions and academia, among others.

The next wave of EVIPNet is being led by the Pan American Health Organization (PAHO) in the Americas. In 2007, PAHO, through its country offices, identified countries that had requested technical cooperation for promoting evidence-informed decision making. Bolivia, Brazil, Chile, Costa Rica, Colombia, Mexico (both the national government and a Mexico–USA border office), Puerto Rico, and Trinidad and Tobago were identified as the first round of EVIPNet participants. Local commitment, as well as the support of health authorities, was essential in planning and developing EVIPNet.
In July, 2007, EVIPNet was introduced to country teams (figure). In addition, PAHO assembled a strong international resource group with expertise in knowledge transfer for policy making. This group provides technical support, participates in network activities, and has been responsible for reviewing country-work proposals. An evidence portal was launched in 2007 to provide access to reliable evidence sources, including the Cochrane Library (in English) and Cochrane Library Plus (in Spanish). The portal was developed jointly by PAHO’s Latin American and Caribbean Centre on Health Sciences Information.9

A global EVIPNet website is under development and will serve as a knowledge-management tool for all EVIPNet teams, by providing them with a one-stop shop for retrieving evidence summaries and other relevant resources. Lastly, an evaluation protocol has been developed to measure the impact of EVIPNet worldwide. This effort is led by John Lavis at McMaster University.

Participating countries have shown tremendous interest and commitment to EVIPNet. What is lacking is ongoing funding dedicated to accessing and promoting research results. For many funding agencies, evidence-informed decision making falls between the cracks. Traditional research agencies see it as development work, and therefore not within their funding remit, while development agencies often consider it within the research realm, and therefore not part of their mandate. Fortunately, a few visionary organisations do recognise that ensuring that the results of research are actually used to inform policy and practice is as important as supporting the production of high-quality research. Other support networks have evolved, and research production and use are becoming components of the public-health agenda in the Americas.10,11

Successful implementation of EVIPNet in the Americas depends on several factors. Ministries of health need to live up to their commitment to EVIPNet by creating mechanisms and long-term strategies that encourage the use of evidence to shape policies, while stimulating a dialogue with the producers of research evidence. EVIPNet teams across Latin America (and around the world), need to work together to share experiences and strengthen their capacities in key areas such as interpreting systematic reviews or summarising existing evidence through the development of policy briefs that address a particular question. Moreover, wealthier countries need to work with those that have fewer resources to stimulate this work. No single person or organisation can influence systematic change. However, if the collective commitment to EVIPNet’s goals currently displayed is any indication of potential future impact, we are on the right track toward ensuring that research evidence is systematically used to improve health.

**EVIPNet Americas Secretariat**
Pan American Health Organization/World Health Organization, Washington, DC 20037, USA
evipnet@paho.org

Written on behalf of the EVIPNet Americas Secretariat by: Sonya Corkum, Luis Gabriel Cuervo, and Analía Porrás, from PAHO/WHO. We thank Fabio Zicker, Tomas Pantoya, and John Lavis from the EVIPNet Resource Group, and José Luis Di Fabio, and Maria Luisa Clark from PAHO/WHO, for constructive comments and guidance. We also thank the Swedish International Development Agency, the Alliance for Health Systems and Policy Research, European Commission Framework Programme 7, and Health Canada for financial support and commitment to EVIPNet. We declare that we have no conflict of interest.

Comment

It has been said that policymakers see research as the opposite of "action" rather than the opposite of "ignorance". How can we overturn such sentiments so that policymakers see research as a means of accessing knowledge and as the foundation for effective action?

In November, 2004, 20 ministers of health and senior policymakers from 52 countries met in Mexico to discuss how research can help them in their daunting task to develop and implement effective health policies.1,2 Informed by the World Report on Knowledge for Better Health,3 the outcomes of the ministerial summit made their way into resolutions at the World Health Assembly in May, 2005,4 with specific steps recommended on how knowledge can be used to strengthen national health systems in the developing world.

A year after Mexico, what progress has been made beyond meetings, reports, and resolutions? How will these ideas translate into reality and, at a practical level, how can ministers and other senior policymakers be better served by research?

EVIPNet (Evidence-informed Policy Network) hopes to provide the answer to these questions. The initiative, launched by WHO in June, 2005, is an innovative attempt to strengthen the links between research and policy in low-income and middle-income countries. Focusing on a bottom-up approach, countries were invited to form national teams and submit letters of intent. A workshop was convened where country teams presented their proposals and worked together to improve them, with assistance from colleagues who had experience of similar initiatives. A final version of these proposals was submitted and is currently undergoing external review for possible funding. Seven proposals were received for the initial planning phase from Laos, Malaysia, Philippines, Vietnam, and China (Sichuan and Shandong provinces, Beijing municipality) to be followed, hopefully, by a longer-term implementation phase over 5 years with more substantial funding.

What is unique about EVIPNet? Country teams were formed with the close involvement of ministries of health, and had to consist of both researchers and policymakers. Although it was explained from the outset that the process is a competitive one, we observed strong camaraderie among participants and a genuine desire to help and learn from each other. EVIPNet also builds on similar, successful recent experiences in the developing world—eg, in Africa5 and Latin America.6 The interaction between participants has already led to the establishment of a regional network, EVIPNet-Asia, and an ongoing electronic discussion platform.7 We hope to extend the initiative to other countries in the region and to other parts of the world. Following the lead set by the Ministries of Health for Kenya, Tanzania, and Uganda for their Regional East African Community networking initiative (REACH-Policy), planning is already underway for the EVIPNet-Africa initiative to be launched in seven further countries in Africa in early 2006.

Will it work? Policy formulation is a multidimensional and complex process, and there is inadequate knowledge...
knowledge about the crucial factors in strengthening links between research and policy. Although much has been written,8–10 information about what actually works is limited, especially in the often challenging setting of developing countries. Questions abound, such as: what constitutes the best evidence and how relevant, feasible, and affordable is this evidence in a developing world setting,11 and what is the role, if any, of knowledge brokers? Herein lies another unique feature and opportunity presented by EVIPNet. Faced with this knowledge gap, together with the belief that the participating countries have valuable experiences of their own to contribute, we decided not to present the countries with a fixed template, model, or framework of best practices developed by so-called experts in the developed world. From the proposals we received it was clear that each country faces a unique set of challenges and constraints, and that this diversity can actually be seized on as an unprecedented opportunity for further research based on a learning-by-doing approach. This research component will be built into the project from the start. Ultimately, EVIPNet will not only result in better policies and stronger health systems, but will also hopefully help to push the boundaries of knowledge in this under-researched area.3

The learning process has already begun as, on the basis of their experiences, participants themselves identified some practical, commonly-shared “drivers” that they felt would enhance their chances of success. Strategic alliances between researchers and policymakers were deemed crucial, and researchers should be involved in scale-up activities. Continuous dialogue was essential, as was the need to simplify and package research on the basis of convincing and accurate evidence. Research should be embedded in implementation and a realistic longer time-frame should be adopted for strengthening links between researchers and policymakers. Access to evidence and information, and national capacity for synthesising and presenting such evidence, were deemed to be critically important, as was a one-stop shopping and rapid-response function to address key policy challenges related to hot topics for government. The participants’ perceptions of important impediments to success were equally valuable. These included absence of quality assurance in research, unavailability of timely data for policymaking, poor communication, poor understanding of the value of research, distortion of evidence, and a shortage of post-policy research. Weak capacity in health-systems research and the absence of an appropriate research agenda were also cited as obstacles.

By providing a bridge between research and policy, EVIPNet hopes to turn research into effective action and problem solving to improve people’s health—arguably the true spirit of the Mexico summit. When the next ministerial summit convenes in Africa in 2008, a review of the effects of this living laboratory will be the true test of its value.

Maimunah Hamid, Thiel Bustamante-Manaog, Truong Viet Dung, Kong sap Akkhavong, Hongpeng Fu, Yuanxin Ma, Xinqui Zhong, Reijo Salmela, Ulysses Panisset, Tikki Pang

Institute for Health Systems Research, Ministry of Health, Kuala Lumpur, Malaysia (MH); Health Policy Division, Department of Health, Manila, Philippines (TBM); Department of Science and Training, Ministry of Health, Hanoi, Vietnam (TVD); National Institute of Public Health, Ministry of Health, Vientiane, Laos (KA); Beijing Centres for Disease Prevention and Control, Beijing, China (HF); Shandong Provincial Health Bureau, Jinan, China (YM); Sichuan Provincial Health Bureau, Chengdu, China (XZ); WHO Western Pacific Regional Office, Manila, Philippines (RS); and Research Policy and Cooperation, World Health Organization, CH-1211 Geneva, Switzerland (UP, TP)

pangt@who.int

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Cochrane Collaboration and the evolution of evidence

The 13th Cochrane Colloquium was held in Melbourne on Oct 22–26.1 The opening plenary session challenged delegates, by asking “is evidence ever enough?” An articulate debate followed, informed by some of the greatest advocates of evidence. Yet the conclusion was that compiling evidence alone is inadequate, and to fully realise the benefit of research, findings must be synthesised in a targeted manner and made readily available at the point of need.

Rather than a downhearted response to this news, reviewers in the 700-strong gathering, or corroboree, appeared full of enthusiasm and imagination about ways in which the Collaboration could shake off its dowdy image and provide more helpful information to consumers. One reason for optimism was the rapid response with text-light, tsunami-tailored evidence earlier in the year, which showed both the value of this unique database and the possibility of rewriting turgid reviews in a form that can be more easily understood and acted on.2 With this impetus, there is now a refreshing interest in expanding the group’s work to include different research designs, complex interventions, more focused outcomes, and wider participation—particularly in the developing world. Cooperative ventures with other health and policy organisations, such as the Australian National Institute of Clinical Studies, to achieve these aims seem likely.

The Cochrane Library has been justifiably criticised for its lack of accessibility, flexibility, and relevance. To be effective, a change in emphasis from the product to its users will need to be more thorough than just rebranding, but must not compromise the rigour and quality for which their reviews are renowned. Much is at stake. If Cochrane fails to become an integral part of daily decision-making, health-care systems, providers, and consumers will continue to be deprived of safer, cheaper, and more effective interventions. However, if “new Cochrane” succeeds, not only will clinical care benefit from the application of established evidence, but the future research agenda will be challenged to provide evidence that focuses on the real needs of patients and those who provide for them.

William Summerskill
The Lancet, London NW1 7BY, UK
Editorials

Global research for health

Should tackle health needs and inform policy

Last week delegations from 59 governments, international agencies, and researchers met in Bamako, Mali, to discuss the state of global health research. It was an opportunity to review progress since their last meeting, four years earlier, in Mexico City, and to set an agenda for the future.¹ The meeting in Mexico is widely seen as a turning point, where the importance of research tackling the greatest health needs was emphasised, and where a strategy for meeting these needs was proposed.

Arguably, in a world with scarce resources efforts should be focused on where they can do most good. To make this happen, those attending the conference in Mexico advocated greater investment in research on health systems and policy, the development of national health research policies, and the incorporation of evidence into health policy.

The consensus is that some progress has been made since Mexico. Funding for health systems and policy research has increased, and some politicians now accept that evidence based policies are desirable.² Yet we still have much to do. The births, lives, and deaths of many of the world's population remain unrecorded.³ Large scale programmes and healthcare reforms are still implemented without evaluation.⁴ The reasons why they succeed or fail are often unknown. And large parts of the world are effectively untouched by health research.

One purpose of a meeting like this is to facilitate dialogue among groups of people who might not otherwise meet. In this it succeeded. Governmental delegations heard about the opportunities offered by health research and the obstacles to achieving them, in some cases seemingly for the first time. Although good intentions often collide with financial and political realities at home, many remarks made by ministers indicated that they had taken the messages on board. But what did the meeting achieve?

The most tangible outcome was a "call to action."⁵ In it, governments committed themselves to developing health research strategies and to funding them adequately, allocating at least 2% of the budgets of their ministries of health. They also committed to creating research infrastructure, including ethical review procedures, clinical trials registries, and open access to data, while promoting knowledge translation as a means of developing evidence based policies. Finally, they accepted the need to build a critical mass of young researchers. Others must also play a role. International development agencies are called on to devote at least 5% of their spending on health to development of research capacity, while they and research funders should pursue innovative financing mechanisms and align their support with national plans.

So what next? The call to action sets out an ambitious agenda, but so did the declaration at the Mexico City summit. An immediate need is to establish a monitoring mechanism that can track progress against stated intentions, so that next time it will be possible to assess what has been achieved and by whom. It is not obvious who should undertake this role, and that fact argues for a reassessment of the often confusing roles of the different bodies that oversee global health research. Yet whoever does it, they should report regularly and publicly, so that governments can be held to account by their populations.

The widespread view was that research funding must change. Short term project based funding should coexist with long term investment in research capacity. Research portfolios should be balanced; they should include basic and applied research, as well as generalisable and context specific studies. These last studies are often the ones that make the greatest difference. The importance of knowledge transfer was stressed, and successes such as the Evidence-informed Policy Network were given as examples.⁶

Calls were also made for partnerships, in which researchers would work with governments, civil society, and more controversially, the drug industry. The last of these stimulated the greatest debate. A few speakers highlighted past transgressions by the industry, seemingly implying that the growth of clinical trials in developing countries was in itself a bad thing. But as Mark Walport, director of the Wellcome Trust, noted, it is industry that makes the drugs that save lives, not academics. Another area of debate was the role of national research strategies. These are clearly important but should not exclude innovative investigator led research.

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The real challenge will be within countries. One of the most striking images was a map of the world, which showed research capacity. The heaviest shading was, as expected, in the developed countries of Europe, North America, and East Asia. Large parts of the map were completely empty, however, in west and central Africa, the Middle East, and the former Soviet Union.

The unresolved challenge is what we should do where there is virtually nothing to build on. Increasing global funding alone will not help. External donors can help, if they are willing to invest strategically and recognise that the results of their funding may take a decade or more to become apparent. However, governments must also act, by tackling the corruption and failures of governance that prevent not just the development of health research but also the development of the basic institutions needed for anything to work.

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Martin McKee, professor of European public health

1 London School of Hygiene and Tropical Medicine, London WC1E 7HT
martin.mckee@lshtm.ac.uk

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References

the impacts of climate change. The Ministry of Health currently works with the Ministry of Local Government to address the issue of dengue and control of the vector aedes aegypti mosquito. Under the National Disaster Management System a National Task Force was established. This is made up of 15 Task groups, with the specific responsibility of planning for, mitigating against and responding to disasters. The Ministry of Health chairs the Health Task Group. The Ministry of Health also works with the Ministry of Agriculture in the surveillance of yellow fever. The Ministry of Health works indirectly with the Ministry of Works and Transport in the areas of clean up campaign and the prevention of flooding.

13. Has your country been involved in work to manage climate change and health at the international level?
Yes. Trinidad and Tobago is a signatory to the United Nations Framework Convention on Climate Change (UNFCCC). A working group has been established that has oversight of the implementation of obligations under the United Nations Framework Convention on Climate Change (UNFCCC).

14. How would you describe the capacity of your country to participate at the global level on climate change and health?
There is moderate capacity. However, the Ministry of Health is continuing to work towards increasing its capacity.
research. Their involvement in research will increase the likelihood that results are used to inform their decisions. Moreover, a greater sense of the utility of health systems research will help to foster greater demand for such research, which will lead to a virtuous cycle. For example the Malawi Emergency Human Resources Programme, which was based on research driven by the Government of Malawi, has resulted in significant improvements in training and retention of health workers within a space of five years (57).

Translation of research into policy and practice can be accelerated by support for appropriate networks and communities of practice. One example of these is the WHO Evidence-Informed Policy Network (EVIP-Net), which promotes the systematic use of health research evidence in policy-making (Box 5). Country teams, linked through regional networks in Africa, Asia and the Americas facilitate policy development and implementation through summarizing evidence, hosting policy dialogues and intensifying exchange between researcher and policy communities (58).
Policy-making is a complex process and research evidence is just one of the many factors that influence policy. For policy-makers, who may not be schooled in research, it can be challenging to assess the quality of research. Furthermore, research results are often nuanced without clear evidence that a particular policy or strategy is effective under all conditions. Accordingly, capacity development is necessary to enhance the skills of policy-maker to apply research evidence in the policy process, and this should be pursued as part of a broader capacity development strategy. Also related are dedicated knowledge brokering functions – supporting evidence-informed policy through encouraging connections that ease knowledge transfer – which are beginning to emerge in low- and middle-income countries, The Zambia Forum for Health Research being one example (59).

The Task Force recommends that:

2.1 mechanisms be developed at country level to ensure that key stakeholders (particularly policy-makers but also civil society) are engaged from identification of research priorities, through conception of studies, to interpretation of findings;

2.2 WHO further develop its knowledge brokering role at country level and also support the emerging knowledge brokering platforms;

2.3 mechanisms be developed that enable the research community and other stakeholders to access relevant research evidence in a succinct and easily understood format, when needed. To accelerate growth of the global knowledge-base on health systems, it is recommended that country, regional and global repositories for evidence on health systems be established, similar to existing repositories for clinical evidence such as the Cochrane Collaborative.

3. **Strengthen country capacity for health systems research backed up by effective regional and global support**

**Country capacities**

There is strong global consensus that strengthening capacity for health systems research – particularly at country level – is the key to progress in the field. Few developing countries have the capacity to perform the analyses and syntheses needed to assist leaders and managers to address public health problems. Instead, they often depend on short-term consultants and advisers for analytical work on health systems. The growing trend in overseas development aid towards technical assistance, which now comprises more than 40% of the value of such aid, is indicative of this systematic bias in support to research capacity (14). This represents something of a substitution of efforts towards developing technical and research capacity on the ground.

There have been some small-scale attempts, such as the now defunct International Health Policy Program (60), to develop capacity in the health systems research field; however the scale of the investment has fallen
into policy decision-making is important. Knowledge generated through research and that is systematically and transparently synthesized through systematic reviews provides a state-of-the-art view of a health problem and of policy options to address it. Social actors gain the most comprehensive and best available evidence when it is drawn from both qualitative and quantitative approaches. Thus, questions of comparative effectiveness (whether one intervention is more effective than another), acceptability (whether interventions fit in social and cultural norms and values), and the satisfaction of healthcare providers and patients are more likely to be addressed. Circulating in advance scientific evidence in a way that is “translated” to meet the needs of each social actor involved improves and facilitates the policy-making process.

What could governments in the Americas do to increase local research production and synthesis in ways that better inform policy-making? First, governments in the Americas must acknowledge the importance of health research to people’s health and to national development. According to various international recommendations, such as those from the Council on Health Research for Development (COHRED), progress in evidence-to-policy in the Americas may be enhanced if national health research policies are first developed and implemented.

The Bolivian government, for instance, lags behind this essential requisite, which is hindering health research priority setting, infrastructure and human capacity building, and focused funding allocation processes. Similarly, the governments of Peru and Ecuador could increase current health research expenditure from 0.10 per cent of their countries’ gross domestic product (GDP) to at least 0.54 per cent of the GDP, the Latin American average. Furthermore, according to a *Lancet* article published by Anastasia Moloney in September 2009, the government of Colombia could increase the number of postgraduate degrees and scholarships on offer, which would increase the current 1.8 per one million Colombian graduates with doctorates annually to at least the Brazilian 50 per one million.

International research and development agencies could also help countries in the Latin American and Caribbean region to ensure they use five per cent of international aid for the health sector on research, as recommended by the CORED in 1990. The largest Latin American economies such as Brazil, Mexico, Chile, and Argentina could also enhance health research partnerships with neighboring countries, and with Canada and the United States.

Second, social actors should support Knowledge Translation initiatives aiming to improve policy and decision-making processes. Such initiatives are comprised of researchers “pushing” evidence to government, civil society and private groups; government, civil society and private groups “pulling” research evidence; and “exchange” among these social actors.

Bolivia, Mexico and Canada are examples of societies striving to foster Knowledge Translation initiatives to varying extents. In 2007, Bolivia and Mexico joined the Evidence-Informed Policy Networks (EVIPNet, www.evipnet.org), sponsored by the World Health Organization. Canada has provided Knowledge Translation expertise and research and development funding to EVIPNet and similar initiatives. The Canadian Coalition for Global Health Research, with the support of the Pan American Health Organization, also organized in 2007 a workshop in Bolivia aiming at perfecting the proposal for research in health for Bolivia. Substantive government stewardship and investment remains essential to strengthen national research capacity in Bolivia.

Mexico’s Knowledge Translation experiences entail relative advancement and complexity. This came about partially due to the Mexican statement in the 2004 Ministerial Summit on Health Research, which called on establishing national Knowledge Translation programmes. Moreover, Mexico’s decentralization of healthcare services increased the autonomy of municipalities and states. Thus, building on close ties between the Mexican Ministry of Health and research institutes, including the National Institute of Public Health, networks composed of researchers, government officials, and activists in civil society groups started to be trained through initiatives such as the Research Consortium for the Development of State Health Systems. This initiative included Mesoamerican countries and counted on Canadian collaboration. Despite Mexico’s attempts to implement such initiatives, it faces challenges common to other Latin American countries: socio-economic inequalities, deficient Knowledge Translation-designated research funding, difficult access to high-quality scientific databases, and lack of expertise.
disseminators, but also proactive actors in policy-making. For example, regular (biennial) regional meetings provide a forum for interactive discussion, sharing and strategic planning.

More recently, with increasing global attention and resource mobilization to address the health workforce crisis in Africa, the Africa Health Workforce Observatory (34) has evolved as part of the action agenda. With its secretariat housed by the World Health Organization (WHO), its mission is to “support actions that address HRH challenges by promoting, developing and sustaining a solid knowledge base for HRH information at all levels: subnational, national, intercountry and regional” (35) (Box 12.2, page 166).

Similarly, with support from WHO, the Eastern Mediterranean Region Observatory on Human Resources for Health grew out of an existing regional observatory on health systems with the purpose “to assist Member States in using a proactive approach and sharing the best and most innovative options to tackle HRH-related challenges” (36). Its outputs in the public domain include updated profiles on the health workforce situation within and across countries, analyses of correlations between significant health workforce
12.4 Opportunities and directions

The development and sustainability of long-term, comprehensive HRH policies and plans is a common challenge for all countries to ensure the health workforce is prepared to meet current and future health system objectives and population health needs with equitable and adequate coverage. In many countries, this entails strengthening institutional capacity for defining appropriate policies and revising them periodically, which itself is dependent upon close cooperation among a wide range of stakeholders in the policy dialogue from the inception stages. This includes not only the ministry of health but also other sectors: finance department, public service commission, educational bodies, health professional regulatory bodies and associations, programme managers (in the public, parapublic and private sectors), development partners and health services users’ groups. In order to achieve balance across the different perspectives, and being mindful that each country has specific challenges and contexts for workforce development, a common framework needs to be identified where collaborative efforts can be focused. To this end, this chapter has examined various strategies and mechanisms to ground HRH policies and strategies in scientific information and evidence.

The sustainable provision of timely, reliable and relevant data, information and evidence to improve HRH policies requires mechanisms to facilitate dissemination, access and use in policy-making processes. Different knowledge transfer platforms (such as EVIPNet) and cooperative mechanisms (health workforce observatories) can offer the opportunity for global and national health institutions to take advantage of the latest innovative and sound tools to support decision-making. Their value lies in the forums they extend to facilitate sharing of information and experiences and promotion of collaborations at the national, regional and international levels.

In particular, health workforce observatories can be a good mechanism to facilitate the steering and negotiating processes of cooperative partnerships. They can contribute to the strengthening of working relations and development of joint agendas among stakeholders. Their informational products help bring new evidence on the health workforce situation to a broader audience, often in a standardized way to foster better understanding and dialogue for comparisons and benchmarking. Perhaps most crucially, they can effectively raise the priority of HRH issues in the health development agenda; for example, through its working groups and mobilization efforts, the Observatories of Human Resources for Health of the Americas network has been credited as central in shaping the agenda for long-term, intentional and coordinated efforts for HRH development at the international, national, regional and subregional levels (43).

A number of critical success factors in moving forward with health workforce observatories and enhancing their benefits have been identified (44). They include:

- championing HRH issues in the country (including high-level political commitment and leadership);
- engaging all key stakeholders in joint planning and nurturing joint work;
- ensuring effective coordination;
- building awareness and capacity in HRH issues;
- developing approaches from different experiences;
- harmonizing standards, definitions and indicators for HRH profiling and analysis;
- supporting networks of HRH researchers;
- institutionalizing coordination mechanisms (mandate and legitimacy);
- creating a communication mechanism for tracing the available information for public use (for example a web site);
- mobilizing resources (technical and financial).

In summary, health workforce observatories and other knowledge transfer platforms present dynamic and evolving networks, which can only stand to benefit from increasing numbers of participating countries and institutions. Securing the initial commitment is often a challenge in establishing such mechanisms, but maintaining interest and commitment (often while coping with political changes and shifting donor priorities) is another critical concern. This requires regular dissemination of products that have proven to be useful, active sharing and exchange of information and knowledge, and continuous advocacy activities. The last-mentioned should including a strong, actionable communications strategy – aimed at policy-makers, managers, researchers and other relevant stakeholders inclusively – to advocate recognition of health workers as the foundation of health systems and implementation of effective strategies to directly address HRH bottlenecks, barriers and funding gaps at all levels.