

Table of Contents

I. The Theory behind the Harmony	2
<i>“The Enchantment with Rationality”</i>	2
<i>The “Casual Empiricism” of the Policy Process</i>	4
<i>What We Talk About When We Talk About Evidence</i>	5
<i>The Policy Pie</i>	7
II. Integrating Research and Policy	9
<i>Towards Linkage and Exchange</i>	9
<i>Knowledge Brokering</i>	13
<i>Knowledge Translation Platforms</i>	14
<i>The Knowledge Base</i>	15
<i>Deliberative Dialoguing</i>	17
<i>Safe Harbours and Chatham Houses</i>	18
<i>Capacity Strengthening</i>	18
<i>Some Concluding Thoughts</i>	20
Six Key Resources	22
<i>Endnotes</i>	24



Chapter 2

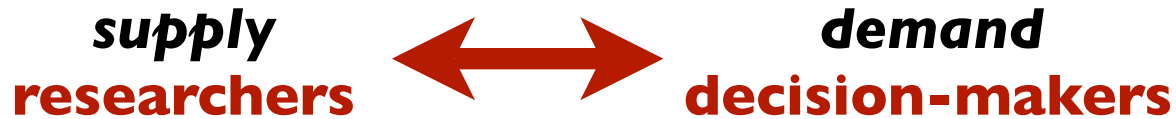
Bringing in the Demand: *Towards the Harmony of Push and Pull*

“There is nothing a government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult”.

John Maynard Keynes

The Mexico City Ministerial Summit of Health Ministers in 2004 stressed partnership between researchers and policymakers, and called for increased involvement of “the demand side” in the research process. Greater involvement of decision-makers in research would axiomatically increase the influence of research and policy. New partnerships and innovative collaborations would explore such things as “knowledge brokering” and modalities for “involving the potential users of research in setting research priorities”.¹

Beyond a doubt, the Mexico Summit was a watershed event for KT. The “know-do” gap became part of the popular lexicon, decision-makers were promoted from their typically passive role as receivers of research, and a promising era of linked knowledge and action seemed upon us. However, missing from the Summit’s excitement was exactly how we might go about forging these new partnerships and collaborations.



Fortunately, there has been serious academic inquiry into the phenomenon of “bringing in the demand”. Unfortunately, it is easy to lose the good ideas and the “what works” strategies within the towering scholarship on the issue. This chapter aims to do two things: first, we demystify the “demand side,” which requires a brief journey into some of the theory behind both the policy process and the nature of evidence. Second, we explore some approaches and strategies that have proven effective. In particular, we focus on effective “linkage and exchange” strategies, on the concept of “knowledge brokering,” and on the development of national-level Knowledge Translation Platforms.

I. The Theory behind the Harmony

“The Enchantment with Rationality”

Most would agree with Caplan (1979) that researchers and decision-makers are two very separate communities. But what does this “separation” really look like? Perhaps the first step in deciphering the demand side is for researchers to understand that their own approach to problem-solving is radically different from a decision-maker’s. Lomas (1997) coined the indicative “enchantment with rationality” to describe the researcher’s typical mindset.² Researchers are indeed besotted by rationality for compelling reasons – good science is a logical, rational affair. Good science creates knowledge that is explicit, systemic and replicable.³ If there is a problem, then a series of experiments – guided by sound methodology – will describe the problem in replicable ways so that what is true today is true tomorrow. Of course there are variations from that ideal model, but the point holds. Researchers find solutions to problems in an ordered, reproducible and logical fashion, and always under the eye of their peers.

“Researchers search for truth by using a rational model... Policymakers search for compromise, by using an intuitive model.”

Source: Choi et al. 2005.

Decision-makers take a starkly different approach to solving problems.⁴ Whereas science solves problems to know, policy solves problems to satisfy. Policy must often appeal to an electorate, accommodate a pressure group, conform to an ideology. The motivations and metrics of decision-making are tethered to other poles. If researchers are rationalists, decision-makers are realists.⁵ They act in a world coloured by compromise.

How to account for this opposed style of problem solving? Can science thrive in a world governed by compromise? Many commentators have posited that a “research-attuned culture” must grow in the policy world, and a “decision-relevant culture” must start to influence researchers.⁶ One way or another, both require deeper insight into the processes that dominate the other’s world. Researchers need to appreciate that policy is

not an event: it is a process.⁷ Like research, policy evolves against a complex and shifting backdrop. Policy does not suddenly “happen”: it unfolds over time under the pressure of many different forces. Researchers must understand that these forces all compete for influence and that scientific evidence is only one kind of “evidence”.⁸ It has a particular – and often circumscribed – place within the policy process.

“The two things one should never watch being made are sausages and public policy.”

Source: Lomas. 1997.

For their part, decision-makers must appreciate that research is not a product: it too is a process. As Lomas (1997) observes, there is no “local research supermarket” where research evidence might satisfy sudden policy hungers. While indeed there are some useful “clearinghouses” of research information, decision-makers must understand that knowledge or evidence can take years to design and develop: in science, there are usually no “quick fixes”. Second, decision-makers must understand that knowledge needs to be contextualized for applicability and utility, and the more they can participate in this process of contextualization, the greater their processes will benefit from science.

As Ginsburg et al (2007) helpfully observe, knowledge translation is a meeting of complex processes within a social environment.⁹ Its foundations are relationships.

Facilitators and Barriers to Research Utilization

In 24 studies, the most commonly mentioned **facilitators** of the use of research evidence in policy-making were:

- personal contact between researchers and policy-makers (13/24);
- timeliness and relevance of the research (13/24);
- research that included a summary with clear recommendations (11/24);
- good quality research (6/24);
- research that confirmed current policy or endorsed self-interest (6/24);
- community pressure or client demand for research (4/24);
- research that included effectiveness data (3/24).

The most commonly mentioned **barriers** were:

- absence of personal contact between researchers and policy-makers (11/24);
- lack of timeliness or relevance of research (9/24);
- mutual mistrust, including perceived political naivety of researchers and scientific naivety of policy-makers (8/24);
- power and budget struggles (7/24);
- poor quality of research (6/24);
- political instability or high turnover of policy-making staff (5/24).

Source: Innvaer et al. 2002.

Evaluations of research utilization have shown that relationships – personal contact – between researchers and policy makers is crucial, and easily the best predictor of research processes influencing policy.¹⁰ No matter the setting – be it in a household or between

countries – good relationships break down walls, they create understanding and trust, and are the great facilitator at bringing radically different processes peacefully together.

The “Casual Empiricism” of the Policy Process

The more we explore the policy process, the more we understand that it is far from a monolith. There are generally three different levels, with different types of policies set at each level. The first is **legislative**, which typically provides the “broad organizational policies” that govern the overall health system and its services.¹¹ Legislative decision-makers are generally held to be non-experts who are interested in ideas, and keen to understand impacts – of both future and prior policies. The second is **administrative**, and here we find policies that dictate how services are run and resources allocated. These decision-makers tend to have strong specialist knowledge and may well use evidence to assist in programme planning. The third is **clinical**, concerned primarily with policies around therapies and corresponding strategies. These clinical decision-makers are typically the greatest users of research evidence, and are receptive to “data on safety, clinical effectiveness, cost-effectiveness, and patient acceptance” – perhaps not simply because they are more attuned to research, but because research is more attuned to them.¹²

Regardless of decision level, “policymaking is not a series of decision nodes into which evidence, however robust, can be ‘fed,’ but the messy unfolding of collective action, achieved mostly through dialogue, argument, influence and conflict”.¹³ In a like vein, Stone (1997) concludes that “*much of the policy process involves debates about values masquerading as debates about fact and data*”.¹⁴ Understanding this “debate about values” is crucial because, when it comes to science, we trust the findings that most agree with our own values. The more aligned *any* knowledge is with our existing value system, the more likely we are to accept it: some may accept abstinence as an evidence-informed AIDS-prevention strategy, while others might brand this approach right-wing, no-Christian dogma. It all depends upon *user perspective*. The more challenging or opposing a piece of knowledge is to our value system, the more we will contest and even disregard it – no matter its strength or relevance.¹⁵ Research that challenges decision-maker values, ideas and ethics, will have a much harder time in proving its validity.

But what exactly do we mean by “values”? A decision-maker may have her own set of values and ethics (e.g. the spread of disease should be contained), but these can be further complicated by the values of culture (e.g. male circumcision should always be performed) and by the values captured in political ideologies (e.g. the state should provide free male circumcision to all who want it). Any argument researchers might present to decision-makers must take these “value layers” into account. Respecting the immutable power of values and ideologies and focusing instead on changing decision-maker *beliefs* (e.g. believing that the African potato will cure AIDS) may well be a more promising approach.¹⁶ As opposed to values, beliefs tend to be much more flexible and fleeting – the facts we’re sure of today can change tomorrow because we all understand that knowledge – whether our own or the general “pool” – is fluid and always evolving.

Scholars have tried to visualize this tangle of science, values and beliefs with different metaphors and images. The policy process has “garbage cans,” it’s a “swampy world,” it’s a delta capturing the run-off of problem streams, policy streams, and political streams.¹⁷ There are numerous studies on where decision-makers get their information, and the characteristics necessary for that information to infiltrate and influence their decision-making (see the text box below). There are descriptions and studies and systematic reviews of the actors involved within policy circles and the many competing strains of evidence competing to inform the policy process. Despite all of this, policy-making remains inscrutable, but these many efforts do reveal one certainty: research evidence is just one type of “evidence”. It must compete with all other types of “evidence” a decision-maker may find relevant, from common sense to “casual empiricism” to expert opinion and analysis.¹⁸

What We Talk About When We Talk About Evidence

“Evidence” means one thing to a researcher (what is proven to be true), quite another to a lawyer (what is said to be true)¹⁹, and something completely different to decision-makers.²⁰ While all of this seems self-evident and obvious, we have an intriguing puzzle on our hands when we consider the term “evidence-based”. If there are different degrees and different meanings to the word “evidence,” what does the term “evidence-based” actually mean?

When it Comes to Research Evidence: what do decision-makers look for?

- **credibility and reliability:** evidence must come from trusted sources to eliminate need for the decision-maker to appraise and assess the evidence. This can be established through: authors’ names, peer recommendations, source of research, familiarity of logos...;
- **quality:** evidence must be current, jargon-free and transparent; must include what worked and what didn’t; and must have recommendations ranked in order of effectiveness;
- **costed:** discussion must include a cost analysis;
- **contextualized:** evidence must be presented within local/national/regional/global context;
- **timed:** evidence appears on issues they’re already working on;
- **connected:** where can they get more information?;
- **customized:** presented evidence must be flexible as it’s often used for: cutting and pasting for presentations; passing on to colleagues; printing for their own use; saving and filing; composing a briefing note;
- **mode of delivery:** electronic format preferred but hard copy also desired.

Source: adapted from Dobbins et al, 2004.

Lomas et al (2005) have distilled “evidence” into three different types. The first is **context-free evidence**, which is what works in general, or knowledge about the overall “potential” of something.²¹ This is typically medical-effectiveness or biomedical research (e.g. male circumcision can be a strong preventative measure to HIV-acquisition in men). The second is **context-sensitive evidence**, which puts evidence into a context that makes it operational or relevant to a particular setting (e.g. male circumcision in LMICs may fail as an intervention due to health system weakness and underlying poverty issues).²² In ways, context-sensitive research can be thought of as where the biomedical meets the social science, or where the quantitative meets the qualitative. Where the

theory meets the reality. Both of these types of “evidence” are captured in systematic reviews (see *Chapter Nine’s* discussion), in other syntheses (e.g. a policy brief – see *Chapters Seven and Eight*), in single studies, and in pilot or case studies.

The third category of evidence is, from our perspective, often the most troublesome – **colloquial evidence**. Roughly defined as any kind of evidence “that establishes a fact or gives reason for believing in something,” it is typically comprised of expertise, opinions, and first-hand experience and realities (e.g. most experts agree that implementing a universal male circumcision policy is impossible because of the current cultural and political environment).²³ Some commentators have suggested that colloquial evidence is useful for plugging the holes that the other types of evidence do not address; it may indeed be critical where the evidence is inconclusive, lacking, or non-existent.²⁴

“Evidence” to Researchers...

impact evidence = effectiveness of interventions;

implementation evidence = effectiveness of the implementation and delivery of policies, programmes, projects;

descriptive analytical evidence = surveys and administrative data about the nature, size and dynamics of a problem, a population, sub-groups or social activities;

public attitudes and understanding = research evidence on the attitudes, values and understanding of ordinary citizens;

statistical modeling;

economic evidence = economic appraisal and evaluation methods, including econometric analysis and modeling;

ethical evidence = withdrawing a programme from one group in order to provide a more cost-beneficial programme for another.

Source: Davies P. 2004.

If these three degrees of “evidence” typically inform the policy process, how do we give weight to each piece of evidence when making a decision? Are all pieces equal, or some more equal than others? The CHSRF (2006) has suggested that weighing up the evidence – assigning a value to each “piece” of evidence – is likely impossible. After all, where is the scale that will allow us to weigh and assess the relative worth and applicability of experience (apples), expert opinion (oranges) and a systematic review (bananas)? While each “piece” in this evidential spectrum deserves careful consideration, even in the absence of a scale we clearly need some sort of mechanism that can weigh the various pieces. Until the creation of a “policy machine,” the only mechanism that seems to work is finding consensus through a “deliberative dialogue” that involves all relevant stakeholders and allows the group to collectively assess the evidence at hand.²⁵ Naturally there are some important and contested issues here such as “what is consensus?”, “who is a relevant stakeholder?” and “what is a participatory methodology?” that every deliberative process will have to answer. We’ll return to this important idea in the “Knowledge Translation Platform” section that concludes this chapter.

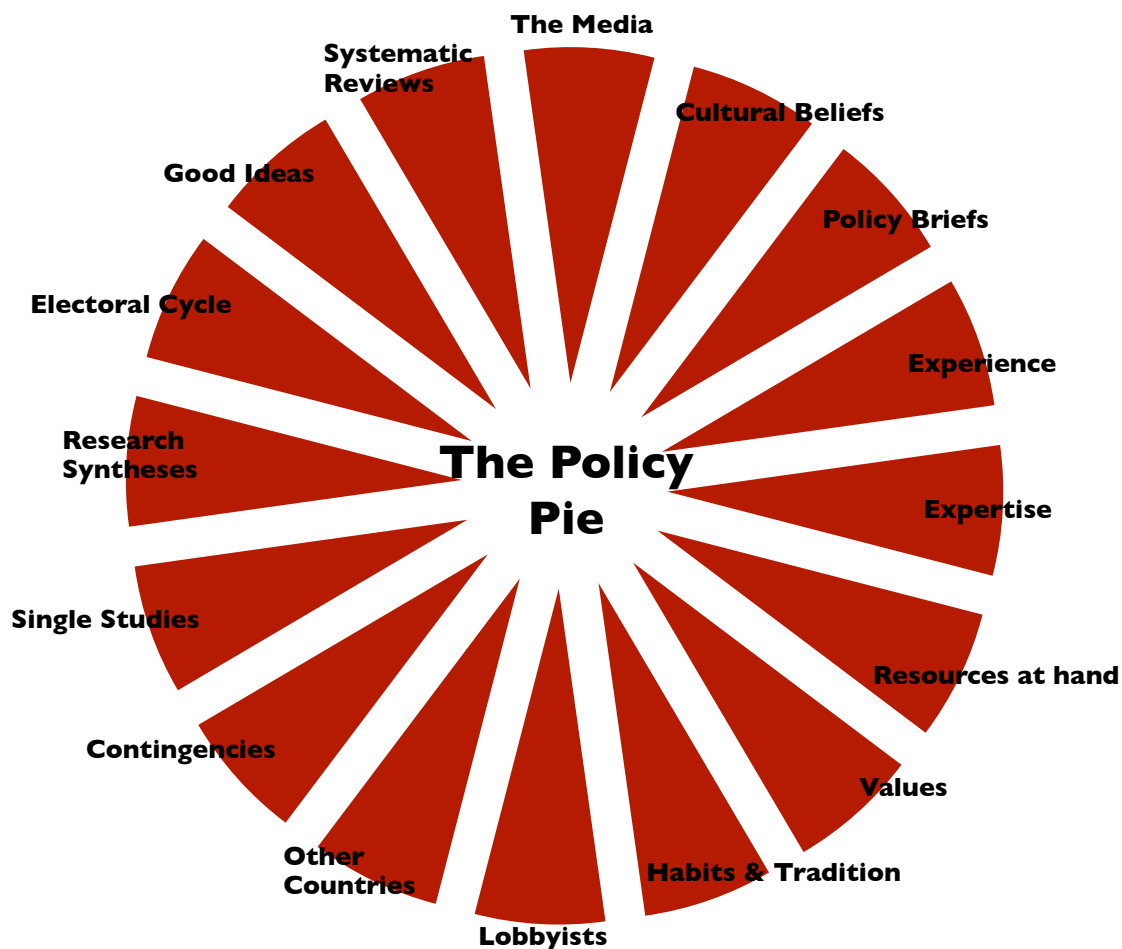
With an emphasis on creating and maintaining personal relationships, **deliberative dialogues** can take any number of forms and formats. They can involve any set of researchers, decision-makers, the media, civil society groups, and donors; can be officially “off-the-record” in that the “Chatham House Rule” prevails and no notes are taken, no quotations attributed; can focus on specific policies; can work to set a research agenda; and on...

The Policy Pie

Clearly, different stakeholders have different notions of evidence, and assign different weights to each piece. And no matter how compelling, scientific evidence (either context-free or -sensitive) is only one ingredient in the policy pie. Of course, the more we know this, and the more we work to integrate our “piece” of evidence into the fuller pie (and situate it relative to others), the greater the odds of our evidence exerting influence.

So this, then, frames everything we talk about when we talk about “evidence”:

1. The audience always defines the meaning of “evidence”.
2. Evidence depends upon *context* to become useful or operational. In other words, it usually requires meaning and interpretation before it can be used.
3. No one “piece” of evidence can possibly address every point a decision-maker must consider in setting policy.²⁶
4. Evidence is *fluid* and evidence is *fallible*. What is true today is not always true tomorrow because *context* is ever-shifting and science is ever-evolving. There are flaws in the peer-review process, context can defeat replicability, and the underlying nature of knowledge is to question and improve upon itself.²⁷ Because research findings must be contextualized to become operational, they become subject to interpretation and as such cannot be free from possible error.²⁸ Nothing, we come to realize, is ever 100% true. So why would we ask decision-makers to base an important policy on something we can’t guarantee will always be true? Politics and decision-making may seem like irrational sports, but *the fact is that they, like science, have evolved over centuries, and have equally strong and compelling reasons for considering a wide range of “evidence” in their decision-making processes.*



With all things considered, perhaps pressing for “evidence-based policy” or even “evidence-based culture” might seem increasingly naive.²⁹ Our discussions of “policy” and “evidence” show both are so slippery as to elude any sort of categorization, let alone a base for action. A growing chorus of authors is underlining this point, emphasizing that “there will never be a generalizable evidence base on which managers and policy makers will be able to draw unambiguously and to universal agreement” and that the idea of evidence-based policy “overlooks or plays down the role of power, uncertainty and chance”.³⁰ One scholar adds that “the evidential base in support of the proposition that evidence-informed decision-making is, in broadest terms, a ‘good thing’ is itself distressingly thin”.³¹

“It is worth heeding the caution ‘evidence-based policy: proceed with care’. For instance, while there may be extensive research on the effectiveness of health-care interventions, there is often less evidence on their cost-effectiveness, implementation, cultural appropriateness and effects on health inequalities, all of which are important considerations for policy-making.”

Source: Haines et al. 2004.

While there might be such a thing as “evidence-based practice” (e.g. incorporating context-free evidence into clinical practice and procedure), the compromise imperative of decision-making all but disqualifies “evidence-based policy”. “Evidence-influenced” or “evidence-informed” seem more realistic targets: they still aim to increase decision-makers’ use of evidence, though in a more humble and context-appreciative way.

$$\frac{\text{(Context-free + context-sensitive + colloquial) evidence}}{\text{(Debate + negotiation + compromise) experience}} = \text{Policy ?}$$

The more that research evidence can understand the workings of this policy formula – not fitting *our* evidence into *their* context, but instead creating evidence that understands and respects the policy process from the very beginning – the more savvy and influential our work might be. As Davies (2007) puts it, we “need to encourage ownership of the evidence, not just the policy”³². As we’ll discuss below, linkage and exchange becomes a primary model in achieving this type of ownership, with the creation of **demand-based evidence** reflecting the needed integration of demand and supply. Far more than creating a viable evidence-base or trying to translate research results directly into practice, pursuing partnerships and creating robust linkages seems to offer the best set of choices in moving our KT agenda ahead.

II. Integrating Research and Policy

Towards Linkage and Exchange

Just as researchers may wish to co-produce policy, they must also encourage decision-makers to co-produce research. There are multiple ways of bringing decision-makers into the world of research – from identifying priorities to designing research to utilizing research findings – with each illustrating how we might move past researcher-driven processes into “co-production processes”.³³ In this section, we’ll look at linkage and exchange efforts through the researcher’s lens.

how when why

When it comes to “bringing in the demand,” the literature identifies such important variables as: **how** they’re involved in the research process; **when** they’re involved; and **why** they might choose to be involved. Are they working behind the scenes, sitting in the front row, or are they actors on stage? Ross et al (2003) outline *how* decision-makers might become involved in research processes:³⁴

- as *formal supporters*, they likely don’t have direct involvement in the research, but do welcome and support it. Beyond a receptivity to the research findings, this support can have other important consequences: it can confer an important air of legitimacy

on the research process, and it can open doors to further resources, information and even other decision-makers.

- as a *responsive audience*, their participation rises, though it remains in response to actions initiated by researchers. This can involve helping to craft the research design, becoming a member of the research advisory team, giving advice on tactics and information, and perhaps becoming involved in collecting data, interpreting results and even creating KT strategies.
- as an *integral partner*, the levels of participation increase dramatically. Here, we see decision-makers as a significant partner often initiating many activities and shaping (even leading) key parts of the process. Critical here is the distinction between observing and executing: integral partners are key team members with a role in executing core strategy.

A fourth (and the “usual”) category would be as “passive audience” – where decision-makers do not participate in the research process and instead passively receive findings and syntheses. They may even actively request these findings, but the point is that they play no role in the research itself. While this is clearly not as desirable as any of the other categories, finding the right decision-maker audiences and getting their ear is vital and could well be the precursor to their more formalized support.

Public Sector Anti-Retroviral Treatment in the Free State, South Africa

This multi-phased research programme is a cutting-edge collaboration between the Free State Department of Health and several different research teams (one studying and training nurses, another the provincial health system, a third the impact of ART on communities). Initially the **audience** of research findings on lung health (the Practical Approach to Lung Health South Africa (PALSA) project), the FS Department of Health approached the PALSA team requesting its assistance in the development and implementation of training activities as well as an overall monitoring and evaluation program for the Free State anti-retroviral therapy rollout. Through discussions with other researchers, the programme was expanded to examine in more detail the effects on clients of health services, possible “system leakage,” and the presenting policy context.

Close personal relationships, open lines of communication, and a decision-maker unafraid to receive “snapshots” of the health system are essential to this programme. Over two phases, it aims to:

1. Support the government’s effort to strengthen the primary health care system to deal with the HIV/AIDS burden in the Free State.
2. Build accountability and improve the effectiveness of the service offer to citizens through evaluating training of health workers and documenting the impact of the rollout at the institutional and community levels.
3. Inform and strengthen public health sector capacity to implement an effective, accountable and equitable ART rollout in the FS and potentially other provinces and other parts of Southern Africa.

For more information, see http://network.idrc.ca/en/ev-59560-201-1-DO_TOPIC.html

When decision-makers become involved – i.e. at what stage in the research process – helps to determine the nature of their involvement, as supporter, responsive audience or partner. Clearly, inviting a decision-maker to participate in the design of a research

project is one smart, logical move, and in fact several current *Calls for Proposals* have this type of requirement for any funding application.³⁵ While specific projects (and the attendant funding) may make participation attractive to decision-makers, as researchers there are a few ideas we might use to increase the chances of a decision-maker choosing to participate in a research project – or even approaching us to create one.³⁶

A decision-maker's potential role in the research process is often dictated by:

- the stage of the research process their participation is wanted;
- the time commitment required;
- the alignment between decision-maker expertise and the research programme;
- the presence of an already existing relationship.

Source: Ross et al. 2003.

At the different stages of the research process, strong linkage and exchange strategies we might employ include:

- **conceptualization stage:** holding *priority-setting exercises*. Though there are different types of exercise, these are typically fora that “translate priority issues into priority research themes” or research questions.³⁷ Priority-setting exercises typically involve a wide set of stakeholders and are guided by criteria for determining the priority of an issue, theme or question – e.g. assessing the urgency and durability of a priority; determining the existing stock of research on the priority; and examining variables such as research capacity to study the priority and decision-maker capacity to participate in the research and uptake possible findings. Convening priority-setting exercises can be a way of cementing researcher-decision-maker partnerships, yet need not be restricted only to decision-makers and researchers.
- **production stage:** designing *collaborative research projects*. While it is indeed possible that not enough decision-makers know what collaborative research is or could be, designing a collaborative research project has clear benefits.³⁸ Denis and Lomas (2003) outline how collaborative research often works to blur the lines between scientists and non-scientists, a true “cooperative endeavour” producing knowledge that is fundamentally usable.³⁹ Collaborative research can bring the investigator into the policy and the policy into the investigation. As opposed to the more traditional “client-contractor relationship where each partner respects the expertise and skills of the other,” collaborative research envisions a true partnership: designing research that will present solutions to health services problems; creating mechanisms to share issues and results; and designing broader KT strategies.⁴⁰ Collaborative research, at bottom, must be characterized by a spirit of give-and-take, with fora and practices enabling collaborators to access and share their knowledge.⁴¹
- **dissemination stage:** creating *knowledge translation strategies*. This goes beyond syntheses and summaries, and into precise road-maps for how research findings can move into practice. This capitalizes on the core strengths of decision-makers – they know the context around the policy and they know how the system works. If researchers provide the science, decision-makers can provide the know-how: how information flows, who needs to see it, and what kind of consensus is needed to push action in a place as

shifting as a Ministry of Health. Attention here might be on the “products” needed to capture relevant knowledge (e.g. a policy brief), and the channels through which they might be disseminated.

- **utilization stage:** creating *knowledge systems* that can use, re-use and demand knowledge. Beyond a framework for the uptake of any particular project’s results, this could include such things as creating robust knowledge management systems that can search, find, capture, extract and even appraise knowledge and evidence. Convening deliberative fora could be a way of ensuring that the vital *tacit* knowledge on any project or issue is shared.
- **stewardship:** inviting decision-makers to participate in the *governance* of research processes. This can include serving on a research organization’s governing board or on a research grant-selection panel.⁴²
- **funding:** inviting decision-makers *to make a financial contribution* to a research project. This reflects the belief that real ownership comes only at an expense, with the CHSRF [no date] advising that funding arrangements should be one of the “first items to discuss” with decision-makers, establishing clear requirements and expectations up front.⁴³ This gets at the point that decision-makers need not always be an active partner but, as in the business world, can be a silent partner with a strong financial stake in any project’s success. Designing joint-funding arrangements indicates mutual commitment.

Beyond the how and the when, is also vital to understand *why* decision-makers may want to be involved in a research process, as this can play a strong role in “selling” participation to them. What are some other **incentives** for decision-makers to link and exchange with our research processes? One of the strongest pitches here rests on the question of *impact* – often the variable of primary interest to decision-makers. *Why* decision-makers may choose to become involved include:

- the ability to create evidence that aligns with their policy needs. Particularly if the policy environment is highly politicized, evidence may well provide the necessary ammunition to push through a particular policy option.
- the ability to create and implement policy and programmes that have already been subjected to scientific (or “expert”) scrutiny. This could include synthesis work highlighting “best practice” or examples from other relevant contexts.
- the ability to evaluate existing policies. In many cases, this is one of the strongest arguments for linkage and exchange, as research can often provide a “moving snapshot” of policies as they unfold, allowing decision-makers to make necessary “mid-course” corrections. For a pre-eminent example of this, see the Free State’s Public Sector ART text box above.

Though not discussed here, *Chapter Four’s* examination of *Context Mapping* may help us think through the many actors within the decision-making process, and who or what department would be the most likely or appropriate to connect with our own processes. Careful understanding of the different “levels” of the decision-making process – from legislative to administrative to clinical; from global to national to provincial/state to local – can again only aid us in our efforts to link and exchange. We must pay attention to the skills and abilities of any decision-maker interested in partnering with us – those with the

free time to work with researchers are sometimes those “out of favour” in the Ministry or career civil servants lacking the needed panache to be a real partner. As with anyone with whom we’d consider “partnering” – from business to sports to marriage – let’s be clear and cautious up front, outlining expectations, needs, abilities and time before we begin. Linking and exchanging with the wrong person or wrong department can be a tremendous time-waster, a squandering of resources, and can even tarnish reputations and careers.

Knowledge Brokering

In an ideal world, a web of vibrant linkages connect researchers and decision-makers. In practice, there is often a disconnection between the two that good intentions or theoretical understandings just can’t bridge. Enter the knowledge broker, either an individual or institution who become “the links between different entities or individuals that otherwise would not have a relationship. Their core function is connecting people to share and exchange knowledge”.⁴⁴ They are an intermediary or “middle man” between the research and policy worlds.

As an intermediary, the broker can play a variety of roles. Most commentators agree that the primary task of any broker is to network – using strong mediation and communication skills to put (and keep) people together. They are not “just selling some solution” but instead work to understand the critical variables of politics, power, and actors.⁴⁵ While the home of a broker may be in research, her terrain is politics and power dynamics.

Among the essential knowledge-brokering characteristics that Jackson-Bowers et al (2006) identify are trustworthiness, credibility, political neutrality, and subject expertise, with issues like seniority, background (academics, policy officers, communication specialists), and location typically differing across contexts.⁴⁶ Beyond networking, the role of the broker can also include:

- synthesizing research (through the creation of policy briefs, systematic reviews, briefing notes). The broker must have basic research skills and an ability to gather, appraise, analyze, synthesize and package knowledge and evidence.
- creating “partnerships around single studies, programmes of research, or systematic reviews to enable them to collectively ask and answer locally relevant questions”.⁴⁷
- facilitating access to data and evidence.
- helping to convene meetings (e.g. providing the space and neutrality for priority setting exercises or national policy dialogues).

“The researcher who takes the trouble to seek out a health system administrator with new findings is doing knowledge transfer but not brokering. That same individual running biannual meetings between her researcher colleagues and the policy branch of a provincial health ministry is acting as a knowledge broker. A communications specialist who translates research into plain language and packages it in an accessible, quick answer format is working on dissemination strategies but not brokering. The same communications specialist acting as a liaison for the ministry, building a network of academic contacts and helping policy planners to develop evidence-gathering projects is brokering.”

Source: CHSRF. 2003. “The Theory and Practice of Knowledge Brokering in Canada’s Health System: a report based on a CHSRF national consultation and a literature review”.

If we return to the issue of “when” decision-makers might intersect with research processes, we can clearly see some specific entry-points for brokers. As one of their principal roles is encouraging a “continuous exchange on many levels – from sharing experiences and searching out existing knowledge to turning management problems into workable questions for researchers to study,” we can imagine the work of brokers including:⁴⁸

- **priority-setting exercises:** brokers may have the necessary neutrality (in both politics and in geography – i.e. possessing a neutral physical space) to convene this meeting, and to chair it successfully, mediating different needs and interests;
- **collaborative research:** brokers may be able to help define the terms for fusing the strengths of research and policy, and provide the needed neutrality for negotiating partnerships;
- **KT strategies:** as one of the core skills of any broker may well be evidence retrieval, appraisal and dissemination – as well as knowing the policy process – this could be a central domain for any broker. Successful broker institutions may well have searchable databases, clearinghouses, and may also provide “rapid response” services that can provide policy-ready responses (see below).
- **funding:** due to their networking and personal contacts, brokers tend to know of funding opportunities, and may well help researchers and decision-makers mediate the terms of funding, especially if there are plans for co-funding arrangements.

Knowledge Translation Platforms

The concept of “Knowledge Translation Platforms” (KTPs) is a logical continuation of knowledge brokering. KTPs are, quite simply, institutions committed to the arts of knowledge brokering. Contexts and shapes may differ, but at heart they aim to nurture and formalize the spirit of linkage and exchange. They exist to serve researchers, decision-makers and other research-users – such as practitioners, the media, and civil society.

In Africa, there have been several noteworthy, embryonic attempts at creating KTPs. One is the Regional East African Community Health Policy Initiative (REACH-Policy), currently based in Kampala, Uganda. Another is the Zambia Forum for Health Research (ZAMFOHR), based in Lusaka, Zambia. It is expected, however, that more and more KTPs will arise, particularly with continuing strong support from entities like EVIPNet, the Alliance for Health Policy and Systems Research, and IDRC.

As knowledge brokers, KTPs are intermediaries between research and policy. Their overall goals are to smooth the movement of research to the policy level; to connect the needs of the policy process with research and researchers; and to infuse public dialogue with an appreciation and understanding of research processes and research evidence. KTPs may find, present and synthesize information; convene meetings; and work to bring actors and processes together. If KT is indeed a series of social processes, then KTPs are the meeting places, the umbrella trees under which ideas can be discussed and debated.

As with any new national or regional actor, setting-up a KTP requires skillful political manoeuvring and a broad acceptance of its role among key stakeholders. This was done in both Zambia and the EAC through deliberative dialogues involving an array of different (and at times opposed) stakeholders. These dialogues are crucial. They not only discuss the terms of stakeholder buy-in, but also refine the technique of dialogue itself. Every country and context will have different dialogue methods; if these can be understood and incorporated into a KTP from the outset, then the role of the KTP as dialogue convener will already be well established.

To be this convener *of* dialogues, it is important – though not essential – for a KTP to be an actual, physical space. Consider the different political overtones in dialogues occurring at a Ministry or a national newspaper or the offices of civil society: the backdrop matters. To that end, KTPs need to have a room large enough for deliberative dialogues, and probably also space for a resource centre. We'll explore these ideas in our consideration of the three connected thematics that wind through a KTP: the knowledge base, deliberative dialoguing, and capacity strengthening. Each of these is at the heart of knowledge translation, and the cornerstones of any KTP.

knowledge dialogue capacity

The Knowledge Base

The knowledge base describes the role of a KTP in defining and identifying knowledge, and then harvesting, preparing and synthesizing it. We use the term “knowledge” broadly, as it can include any kind of data or information that a KTP deems relevant. If a KTP is to be a trusted source or clearinghouse of the knowledge *that stakeholders want*, it must have that knowledge on hand. Creating a dynamic knowledge base can see a KTP:

- determining, perhaps through a deliberative dialogue, **the type** of knowledge it wants to capture – e.g. single studies, systematic reviews, grey literature, project profiles and reports. This could also take a more targeted approach – e.g. capturing all research on malaria prevention and treatment.
- scanning the environment to determine the knowledge **other institutions already possess**, both electronically and in hard copy. This could include university libraries, UN agencies (eg UNAIDS), government parastatals (e.g. National AIDS Committees), and NGOs (both domestic and international).
- collecting all **relevant** knowledge (including research evidence, syntheses, reports, project profiles, etc). This could include **site visits** to the organizations or individuals who possess the needed information.
- **creating systems** that allow users to search and access it (e.g. databases, websites, and dialogues for sharing tacit knowledge) in the understanding that the KTP need not duplicate other systems but rather find ways of tapping into or adding value to them.

Once a strong knowledge base has been established, KTPs may then progress to the next step and add value to this store of knowledge. This could include:

- **synthesizing research:** typically systematic reviews, meta-analyses and policy briefs. It could also include conducting (user-demanded) searches for relevant studies and reviews, and providing this “information service” for other research-users. The KTP may go further and assess the quality and local applicability of such evidence. It may also contract out the production and regular updating of syntheses, especially where none exist or the quality is questionable.
- **creating rapid response units:** accessible by telephone, email or website, these units can provide fast, up-to-date information for research-users who may wish to know, quickly, the evidence supporting position x or y, or who may want an expert’s opinion on a particular issue. A rapid response unit’s core functions are to search for syntheses, conduct assessments of their quality and local applicability, or commission them where none exist. Rapid response units may also conduct briefings with decision-makers based on the material they find in response to particular questions.

Connected to the issue of “synthesizing” research is the broader aspect of packaging and communicating key messages in attractive, user-friendly formats. Working from their strong knowledge base, KTPs may focus some of their energies on:

- developing “**friendly front-ends**” that provide “graded entry” for decision-makers. According to the CHSRF’s formula, a “graded entry” reduces a complex issue (or paper or body of evidence) into one-page of central “take-home messages” and a more detailed three-page executive summary which would highlight any issue’s benefits, harms/risks, costs of policy alternatives, and factors that might influence local applicability.⁴⁹ This is often called the 1:3:25 approach, with the “25” representing the full paper or synthesis. Clearly, each 1:3:25 product has a different research-user audience in mind.

- producing a “**Who’s Who**” Directory that documents all of key health research (or even health) stakeholders domestically, including details of institutional affiliation, papers, grants, etc. and contact information.
- developing **annual reports or newsletters** that discuss a range of issues, including gaps in research, “orphaned” research issues, features on successful instances of research and policy collaboration, and bringing in pertinent evidence-to-policy examples and personalities from other sectors or countries.

Deliberative Dialoguing

There is a mountain of literature on deliberative processes, with a predictable variety of necessary dialoguing ingredients in every article, journal and book. Ultimately, if KTPs aim to be a neutral and trusted space for dialogue, incorporating sound deliberative processes is essential. A deliberative dialogue is more than a meeting. As its purpose is to provide contextualized “decision support,” the methodologies guiding a deliberative dialogue need to be taken very seriously – dialogues are almost always politicized, with supporters on either side of an issue.⁵⁰ A KTP must decide whether it wishes to take a position on certain issues, understanding that such advocacy may impair its neutrality, which in turn may weaken its overall credibility and stature.

Most deliberative dialogues tend to be issue-specific – a dialogue on “health research” would likely be too unwieldy, whereas one on “malaria treatment” may well provide the needed focus. Deliberative dialogues discuss “evidence,” which can naturally mean all kinds of different things depending on the audience involved. The CHSRF (2005) stresses that deliberative dialogues should include “criteria for the sources of evidence and their weight, and a mechanism for eliciting colloquial evidence,” in the end taking the prescriptive stance that deliberative dialoguing is “to ensure scientific forms of evidence take priority over colloquial evidence”.⁵¹ With the core issue of neutrality in mind, we might do better to think of deliberative dialoguing as a guarantor of this priority – as a chance for scientific evidence to be heard and assessed.

For any of these issue-specific dialogues, KTPs need to think through a range of essential issues. These include:

- **participation:** who’s invited? What institutions do they represent? What degree of inclusion do we need? Have we included civil society? Practitioners? Will we include more than one expert discipline?
- **“evidence”:** what evidence on the issue is out there? How can the dialogue weigh up the competing forms of evidence? How can the KTP work to combine the evidence? How will the KTP (or the dialogue itself) resolve conflict over evidence (and/or over other values)?
- **facilitation:** who will chair the meeting? Should an outside facilitator be brought in?
- **logistics:** is there material every attendee must read in advance? How to ensure that there is time for questions and space for dissenting or minority views?

Safe Harbours and Chatham Houses

A “safe harbour” is literally a place one can take refuge in, and find safety from bad weather or attack. A Safe Harbour meeting could thus be an informal meeting where there are no “stupid questions” – or, rather, no *record* of stupid questions – and thus a key way for science to become understood, and for decision-makers to interact with it. Given our discussion of all the competing evidence jockeying for inclusion on the policy pie, if decision-makers don’t understand scientific evidence, they won’t use it. They have plenty of “evidential” alternatives.

Often critical to these meetings is the “Chatham House Rule,” which dictates that the meeting may be discussed in the “outside world” but only on the condition that there is no attribution, no record of “who said what”. As *Wikipedia* relates, “the Chatham House Rule evolved to facilitate frank and honest discussion on controversial or unpopular issues by speakers who may not have otherwise had the appropriate forum to speak freely”.⁵² While clearly this would not be an appropriate methodology for all meetings, it may have particular utility where decision-makers may feel intimidated or confused by the scientific evidence, or where they wish to discuss political pressures.

The dialogue around the creation of the REACH-Policy initiative identified the need for “safe harbour” meetings – events where delegates could “discuss the take-home messages from research syntheses and their implications for high-priority policy issues”. The EVIPNet teams have modified this into a “National Policy Dialogue” to emphasize the level (national) and the task (discussing a national policy).

For more information, See the REACH Prospectus at www.idrc.ca/geh/ev-101251-201-1-DO_TOPIC.html

Capacity Strengthening

As our final “triad” in this discussion of KTPs, capacity strengthening represents a vital “cross-cutting” activity crucial to the functionings of any KTP. While the knowledge base creates a critical mass of information and resources, and deliberative dialoguing creates an open space to discuss and contextualize that knowledge, a capacity strengthening approach can knit the two together.

Though a KTP can contribute directly to capacity strengthening through its knowledge base (good knowledge management systems and user-friendly content = accessible and understandable science), and through its deliberative dialogue support (open spaces and multilevel networking = increased opportunities for learning), it can make its strongest contributions to capacity strengthening through regular and consistent **training courses**. These can be offered through the KTP or be advertised by the KTP. Additionally, the KTP can, on behalf of institutions like the Cochrane Collaboration or the CHSRF, usefully identify individuals who would benefit from existing training opportunities elsewhere.

REACH-Policy: Knowledge, Dialogue, Capacity		
Process	Activities	Outputs
<i>Knowledge Base</i>	conduct searches for syntheses; connect with EAC partner state information bases; create clearinghouse for one-stop shopping; maintain website; create rapid-response unit to search, conduct, commission syntheses. Develop friendly front-ends.	Functioning clearinghouse. Databases. Website. Rapid-response unit. Packaged syntheses. KT strategies. Annual reports, newsletters.
<i>Deliberative Dialoguing</i>	hold priority-setting exercises; convene safe harbour and national policy dialogue meetings.	Policy and research priorities aligned. Consensus on priorities. Policy-driven research syntheses. Evidence-informed policies created.
<i>Capacity Strengthening</i>	Provide policymaker training in how to acquire, assess, adapt, apply research. Provide training for researchers in the policy context; how to create syntheses; how to lead or participate in KT activities.	Training workshops. Briefings for high-level decision-makers.

As with all other KTP core functions, deliberative dialogues may identify the training needs of specific researchers and research-users the KTP serves. This may include offering training to:

- **decision-makers:** in acquiring, assessing, adapting and applying research. Critical appraisal skills have been routinely identified as an element decision-makers want to learn more about. They may also want skills in organizational change theory and knowledge brokering.⁵³
- **researchers:** in methodology, resource mobilization, knowledge translation, literature retrieval, and the policy process itself. Much more so than decision-makers, researchers tend to be very frank and upfront about what their training needs are, and how best a KTP might serve them.
- **the media:** in identifying subject experts, acquiring and assessing research, and in knowledge translation.
- **civil society:** in the research cycle, and, like decision-makers, in acquiring, assessing, adapting and applying research.

The Zambia Forum for Health Research (ZAMFOHR): Resource Centre Plans

In February 2008, ZAMFOHR held a deliberative dialogue over its plans to launch a Resource Centre that would serve the many different research-users in Zambia, with a particular focus on capacity strengthening. With representatives from academia, civil society, the government, the media, and international donors, a facilitator from Tanzania guided the group through:

- a discussion of Resource Centre examples in Africa and beyond; and
- a review of existing Resource Centres in Zambia itself.

Then the delegates discussed the core duties for the ZAMFOHR RC and decided that its priority service categories were to:

1. Harvest, filter, and synthesize research and evidence;
2. Disseminate and communicate research and evidence;
3. Build capacity at the interface connecting research with research users;
4. Provide reference information (collect, store, manage, make accessible).

For more, see www.zamfohr.org

Some Concluding Thoughts

We have covered a tremendous amount of ground in this chapter, by necessity glossing over some key concepts, even ignoring some central ones altogether. It should be stressed once more that “bringing in the demand” is still far from an art or science, and that any discussion of it invariably misses key aspects or fails to draw on some essential examples.

With that caveat, here is a list of the “take-home” messages and arguments from this chapter:

1. Context is king, queen and court. The more we know about any context (using, for instance, some approaches from *Chapter Four's* discussion of **Context Mapping**), the greater our chances of influencing decisions.
2. Knowledge is fallible and fluid. What is true today is not always true tomorrow because context is ever-shifting and science is ever-evolving.
3. Researchers rationalize and decision-makers compromise.
4. “Evidence” is slippery, elusive and always user-defined. The challenge in KT is to bring context-free and context-sensitive evidence to the level of colloquial evidence so that all can be discussed and weighed in turn.
5. All kinds of “evidence” compete for a place in the policy pie. If science cannot make itself understood within the policy context, decision-makers will rely upon other kinds of “evidence”.
6. The policy process has sharply different levels and actors of different capabilities.
7. Researchers need to focus more on changing beliefs and less on challenging values.
8. KT practitioners need to encourage ownership of the evidence, not just the policy. Let's move past old terms and start talking about demand-based evidence or even demand-based practice.

9. KT is a meeting of processes within a social environment. If research is not a product but a process, and policy is not an event but a process, KT works to bring those processes together, finding solutions by adding context and dialogue.
10. “Linkage and exchange” depends upon how, where and why decision-makers are involved in the research process.
11. Knowledge brokers are neutral actors on a stage of politics and power. They are trusted and instrumental resources for bringing together the worlds of research and policy.
12. Knowledge Translation Platforms are built upon knowledge bases, deliberative dialogues, and capacity strengthening.
13. Deliberative dialoguing creates contextualized decision support for national research priorities and national policies. They can also determine the functions of a KTP; the nature of a KTP’s knowledge base; and the capacity-strengthening courses offered through a KTP.
14. Capacity strengthening can expand the appreciation of research processes and scientific “evidence” among a range of research-users.

Six Key Resources

Lomas, Jonathan. 1997. “Improving research dissemination and uptake in the health sector: beyond the sound of one hand clapping”. McMaster University Centre for Health Economics and Policy Analysis. *Policy Commentary C97-1*, November 1997.

As the former CEO of the CHSRF, Lomas investigated KT, the know-do gap and the demand side as much as anyone. Though he has written numerous excellent articles, this 1997 work remains an undeniable masterpiece.

The CHSRF website.

Reflecting the work of its former CEO, the CHSRF’s website is loaded with papers, approaches and projects that show the many different facets of linking supply with demand.

Davies, Philip. 2004. “Is Evidence-Based Government Possible?”. Paper presented at the 4th Annual Campbell Collaboration Colloquium, Washington D.C. 19 February 2004.

Davies does a remarkable job here of discussing and analyzing the different types of evidence jockeying to influence decision-makers.

Innvaer, Simon, Gunn Vist, Mari Trommald and Andrew Oxman. 2002. “Health policy-makers’ perceptions of their use of evidence: a systematic review”. *Journal of Health Services Research & Policy*. Vol 7: 4. pp 239-244.

Innvaer et al use a synthesis tool to look back on how synthesis – among other things – have influenced, or not, decision-makers.

Hammersley, Martyn. 2005 “Is the evidence-based practice movement doing more good than harm? Reflections on Iain Chalmers’ case for research-based policy making and practice”. *Evidence & Policy*. Vol 1:1. pp 85-100.

While there are a number of texts challenging conventional wisdom of “evidence-based practice,” Hammersley does a fine job of summarizing the argument for caution in assembling and relying upon an evidence base.

Lavis, John, Jonathan Lomas, Maimunah Hamid, Nelson Sewankambo. 2006. “Assessing country-level efforts to link research to action”. *Bulletin of the World Health Organization*. 84:620-628.

This paper has an excellent break-down of the different “models” of knowledge translation – push, pull, linkage and exchange, and knowledge translation platforms.

Comments? Questions? Criticisms?

Email the *Research Matters* Programme Officers:

Nasreen Jessani at njessani@idrc.or.ke

Graham Reid at greid@idrc.or.ke.

Research Matters (RM) is a collaboration of the International Development Research Centre (IDRC) and the Swiss Agency for Development and Cooperation (SDC). RM was launched in 2003 to examine and enhance the specific KT dynamics within the field of health systems research. From these founding connections with both a research funder and a bilateral donor, RM has occupied a unique vantage among health researchers and research-users. By working directly with both the producers of research and with its consumers, RM has developed a range of activities and modalities designed to hasten the movement of research results to the policy arena, to database and access those results, to communicate them, and to expand an appreciation of research itself. RM builds capacity among researchers to perform their own KT; RM responds to the priorities of major research-users; and RM actively brokers both research results and research processes. As an active, ground-level embodiment of KT, RM has helped to shape how health research is demanded, created, supplied, and ultimately used.

Endnotes

¹ Keynes cited in Davies P. 2004. “Is Evidence-Based Government Possible?” Paper presented at the 4th Annual Campbell Collaboration Colloquium. Washington DC. 19 February 2004. For details on the Ministerial Summit in Mexico City (2004), see the “Mexico Statement on Health Research: Knowledge for better health: strengthening health systems.” At http://www.who.int/rpc/summit/agenda/Mexico_Statement-English.pdf

² Lomas J. 1997. “Improving research dissemination and uptake in the health sector: beyond the sound of one hand clapping”. McMaster University Centre for Health Economics and Policy Analysis. Policy Commentary C97-1, November 1997.

³ Lomas J, Culyer T, McCutcheon C, McAuley L and Law S. 2005. “Conceptualizing and Combining Evidence for Health System Guidance”. *Final Report*.

⁴ We’ve chosen to use the term “decision-maker” here because we believe it captures a greater range of daily activities and duties than does “policy-maker,” as well as reflecting the many non-policy decisions made at the policy level. Text box quotation from Choi B, Pang T, Lin V, Puska P, Sherman G, Goddard M, Ackland M, Sainsbury P, Stachenko S, Morrison H, Clotey C. 2005. “Can scientists and policy makers work together?” *Journal of Epidemiology and Community Health*. 632-637.

⁵ see Lawrence R. 2006. “Research dissemination: actively bringing the research and policy worlds together”. *Evidence & Policy*. Vol 2: 3. pp 373-84.

⁶ Lavis J, Ross S, McLeod C, Gildiner A. 2003. “Measuring the impact of health research”. *Journal of Health Services Research & Policy*. Vol 8: 3. pp 165-170. See also Lawrence (2006), Lomas (1997).

⁷ Lomas (1997)

⁸ For a fuller discussion see Black N. 2001. “Evidence-based policy: proceed with care”. *BMJ*. Vol 323. August 4 2001.

⁹ See Ginsburg L, Lewis S, Zackheim L, and Casebeer A. 2007 “Revisiting interaction in knowledge translation”. *Implementation Science*. Vol 2: 34. For a discussion of social processes and the “communicative perspective” see Golden-Biddle K, Reay T, Petz S, Witt C, Casebeer A, Pablo A, Hinings CR. 2003. “Toward a communicative perspective of collaborating in research: the case of the researcher-decision-maker partnership”. *Journal of Health Services Research & Policy*. Vol 8: suppl 2. pp 20-25. 2003 .

¹⁰ See Lomas (1997). Also see Innvaer S, Vist G, Trommald M, and Oxman A. 2002. “Health policy-makers’ perceptions of their use of evidence: a systematic review”. *Journal of Health Services Research & Policy*. Vol 7: 4. pp 239-244. Also see Jackson-Bowers E, Kalucy I, McIntyre E. 2006. “Focus on Knowledge Brokering.” *Primary Health Care Research & Information Service*. December 2006.

¹¹ See Hanney S, Gonzalez-Block M, Buxton M, and Kogan M. 2003. “The utilization of health research in policy-making: concepts, examples and methods of assessment”. *Health Research Policy and Systems*. Vol 1:2. See also Dobbins M, Rosenbaum P, Plews N, Law M, and Fysh A. 2007. “Information transfer: what do decision makers want and need from researchers?”. *Implementation Science*. 2:20. 2007. Also Jacobson N, Butterill D, and Goering P. 2003. “Development of a framework for knowledge translation: understanding user context”. *Journal of Health Services Research & Policy*. Vol 8: 2. pp 94-99. Finally on this point, see Lomas (1997).

¹² Lomas (1997), for a breakdown and discussion of the respective decision-making “levels”. Also see Dobbins (2007).

¹³ Greenhalgh T and Russell J. 2005. “Reframing Evidence Synthesis as Rhetorical Action in the Policy Making Drama”. *Healthcare Policy*. Vol 1:1.

- ¹⁴ Stone cited in Greenhalgh and Russell. 2005.
- ¹⁵ Ginsburg et al (2007), Jacobson et al (2003), and Davies (2004).
- ¹⁶ For more on this, see Black (2001).
- ¹⁷ For a recent discussion of Kingdon's various policy models, see Fafard P. 2008. "Evidence and healthy public policy: insights from health and political sciences". National Collaborating Centre for Healthy Public Policy. See also Lawrence (2006) and Hanney et al 2003.
- ¹⁸ Hanney et al 2003, and citing Lindblom and Cohen in same.
- ¹⁹ For a fine quote from Eisenberg (2001): "Law relies on evidence of the instance; health care relies on evidence of the generalizable," see Cuyler T. [no date] "Deliberative processes and evidence-informed decision-making in health care".
- ²⁰ For a full discussion of this, see Davies P. 2007. "Evidence-Based Government: How do we make it happen?". Presentation given to the Canadian Association of Paediatric Health Centres. Montreal, 15 October 2007. Also see Choi B, Pang T, Lin V, Puska P, Sherman G, Goddard M, Ackland M, Sainsbury P, Stachenko S, Morrison H, Clottey C. 2005. "Can scientists and policy makers work together?". *Journal of Epidemiology and Community Health*. Vol 59: pp 632-637.
- ²¹ Lomas et al (2005) and Cuyler [no date]. Text box reference to Dobbins M, DeCorby T, Twiddy T. 2004. "A Knowledge Transfer Strategy for Public Health Decision Makers". *Worldviews on Evidence-Based Nursing*. Vol 1:2. pp 120-28.
- ²² Lomas J. 2005. "Using Research to Inform Healthcare Managers' and Policy Makers' Questions: From Summative to Interpretive Synthesis". *Healthcare Policy*. Vol 1:1. pp. 55-71.
- ²³ Lomas (2005)
- ²⁴ Davies (2004)
- ²⁵ Lomas (2005)
- ²⁶ Hammersley (2006)
- ²⁷ For a discussion of issues around the peer-review process, see Grayson L. 2002. "Evidence-based policy and the quality of evidence: rethinking peer review". ESRC UK Centre for Evidence Based Policy and Practice. For a discussion of the failings of the evidence-based approach, see Hammersley M. 2005 "Is the evidence-based practice movement doing more good than harm? Reflections on Iain Chalmers' case for research-based policy making and practice". *Evidence & Policy*. Vol 1:1. pp 85-100.
- ²⁸ See Hammersley (2005).
- ²⁹ See Hammersley (2005) for an excellent discussion of this.
- ³⁰ Greenhalgh (2005) and Hammersley (2006). Also Davies (2004)
- ³¹ Cuyler [no date]
- ³² Davies (2007)
- ³³ Lomas (2005) and Haines A, Shyama K, and Borchert M. 2004. "Bridging the implementation gap between knowledge and action for health". *Bulletin of the World Health Organization*. 82: pp 724-32.

³⁴ See Ross S, Lavis J, Rodriguez C, Woodside J, Denis J-L. 2003. “Partnership experiences: involving decision-makers in the research process”. *Journal of Health Services Research & Policy*. Vol 8: Suppl 2.

³⁵ See, for instance, the periodic Calls for Proposals from the Alliance for Health Policy and Systems Research at <http://www.who.int/alliance-hpsr/callsforproposals/en/>

³⁶ Beyond any particular research project, we might do well to keep the big picture and the long-term in mind by trying to cultivate *system-level partnerships* that can reap benefits for years to come

³⁷ Lomas J, Fulop N, Gagnon D, Allen, P. 2003. “On being a good listener: setting priorities for applied health services research”. *Milbank Quarterly*. 2003. 81:3. pp 363-88.

³⁸ CHSRF. [no date]. “How to be a good research partner. A guide for health-system managers and policy makers”. At http://www.chsrf.ca/other_documents/partner_e.php

³⁹ Denis J-L and Lomas J. 2003. “Convergent evolution: the academic and policy roots of collaborative research” *Journal of Health Services Research & Policy*. 8:1-6

⁴⁰ See CHSRF “How to be a good research partner...”

⁴¹ See Golden-Biddle (2003).

⁴² see Lawrence (2006) and Jackson-Bowers et al (2006).

⁴³ CHSRF “How to be a good research partner...”. See also Martens P and Roos N. 2005. “When Health Services Researchers and Policy Makers Interact: Tales from the Tectonic Plates”. *Healthcare Policy*. 1:1. pp 73-84.

⁴⁴ CHSRF quotation cited in Jackson-Bowers et al (2006)

⁴⁵ Cullen 2001 cited in CHSRF. 2003. “The Theory and Practice of Knowledge Brokering in Canada’s Health System: a report based on a CHSRF national consultation and a literature review”.

⁴⁶ Jackson-Bowers et al (2006)

⁴⁷ Lavis J, Lomas J, Hamid M, and Sewankambo N. 2006. “Assessing country-level efforts to link research to action”. *Bulletin of the World Health Organization*. 84:620-628.

⁴⁸ CHSRF (2003).

⁴⁹ For a discussion of friendly front-ends, see Lavis J, Davies H, Gruen R, Walshe K, and Farquhar C. 2006. “Working Within and Beyond the Cochrane Collaboration to Make Systematic Reviews More Useful to Healthcare Managers and Policy Makers”. *Healthcare Policy*. Vol 1: 2.

⁵⁰ Lavis J. 2006. “Moving forward on both systematic reviews and deliberative processes”. *Healthcare Policy*. Vol1:2.

⁵¹ see Lomas J, Culyer T, McCutcheon C, McAuley L and Law S. 2005. “Conceptualizing and Combining Evidence for Health System Guidance”. Final Report. Also see CHSRF. 2006. “Weighing up the Evidence: making evidence-informed guidance accurate, achievable, and acceptable”. A summary of the workshop held on September 29, 2005.

⁵² For more, see http://en.wikipedia.org/wiki/Chatham_house

⁵³ Dobbins et al (2004)