The Changing Landscape of Global Public Health: Thematic Area Presentations & Knowledge Network as Vehicles for Transformations
October 26, 2010

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

ALASTAIR AGER: Okay, thank you, and you can do the math as well as me. We have an hour for this session. We have eight groups. That's seven and half minutes per group. I'm asking rapporteurs to speak to the core issues of the PowerPoint and then have a little chance for dialogue in respect to what the different groups were researching.

I think we'll go through in numerical order, which means we'll be looking at Changing Health Prevention Needs first in groups one and two. Group one, because they were being quite visual, are actually not going to be using the PowerPoint because they were depicting in a different way, but can I come to the rapporteur of group one, please, to summarize?

And just take the microphone here. [Inaudible] Okay.

SANDRO GALEA: Okay. So I have the thankless task of summarizing a very vibrant discussion, and it will not take seven minutes. So briefly, what we talked about in tackling this is that you cannot address this question without framing three underlying buckets that need to be borne in mind in the substance of what I'm going to say.

And these three buckets are: there is an unquestioned ongoing need for research and monitoring as it intersects with all the changing health indicators. There is a consistent and

persistent need for health advocacy on the fundamental determinants of the health of populations and there is a dramatic need for attention to developing a global health workforce that can deal with the changing health needs of populations.

So we really felt that these three notions underlie everything else that we're talking about and we couldn't think of a way to do it other than to present it as front and central this way. So having said that, we then dealt with the what by creating an exercise which I'm going to lead you through, which actually we meant to be illustrative rather than comprehensive.

So briefly what we did is, we were interested in trying to map out the intersection between cost benefits of tackling particular health indicators with the potential value of a global effort around those indicators. So as an exercise, we tackled two big buckets of indicators, and again, we don't mean this to be comprehensive, but rather illustrative. We tackled health threats related to aging and we tackled dimensions of mental health. Those are the two buckets that we tackled that we had time for.

And for each of them, what we asked ourselves is, what is the cost benefit of approaches to prevention, approaches to treatment, and approaches to care? And then, what we asked ourselves is, given that, would that benefit from a global

effort, and by global effort, we mean global in contrast here to national or sub-national efforts.

So just to give you a sense of what I mean in aging, we tackled cardiovascular disease, arthritis, Alzheimer's, diabetes and cancer. We split cancer into two, lung and breast, for reasons you'll see in a second. And under mental health we tackled depression, severe mental illness and substance dependence.

So following across, looking at cardiovascular disease, we thought the cost benefit of preventive efforts for cardiovascular diseases are four. Treatment, we have this notation here which is a slash, which actually means south compared to north, which there is a gap, there is a tremendous gap in differences around providing treatment for cardiovascular disease. And investment in care, we gave – we thought was a three. Arthritis, a zero, a gap in treatment, care is a three. All the way down these conditions.

Then, we went back and said now which of these conditions and these access would benefit from a global effort? So for example, we actually thought that the prevention of cardiovascular disease merited a three, a global effort could make big steps there. Similarly, the prevention of substance dependence is a four on global effort because it could really benefit from a concentrated global effort. So in doing that

what we found emerge, and I think I can speak honestly for my group when we actually didn't realize what would emerge when we were doing this, is that intersection of global effort and cost benefit focuses us on the prevention of cardiovascular disease, the prevention of diabetes, prevention of lung cancer, and of substance dependence from this illustrative list.

So we actually thought that a paradigm like this in a bit more time and a bit more of a focused way, that really asks the question, what are the health indicators that would benefit from a global effort and what aspects of dealing with those health indicators would the global effort benefit, could help us, and by us I mean the broad global public health community, hone in on where we want to focus our efforts within a universe of constrained resources.

That is as far as we got. I'm going to turn it over to my colleagues to see if they have something to add.

ALASTAIR AGER: Is there anything on the who and how that – I'm just checking – you got to in terms of engaging in that?

SANDRO GALEA: We thought that our what was so good that we were not going to address [laughter] the who and the how.

ALASTAIR AGER: Let me throw it open to the whole room, and that would include table one. So any observations, any

comments, we'll do this for each group just to have a brief piece of discussion. John Beard, right to the far side.

JOHN BEARD: John Beard, Director of Aging with WHO and thank you, Sandra, I've been struggling with this for almost two years trying to figure out what we should do and you've solved my problem for me.

SANDRO GALEA: Any time.

JOHN BEARD: My only comment though, is that it's a very disease focused. And as we have been struggling with this at WHO, I've been thinking also about healthy aging and how we can actually keep older people engaged in the community and productive and prevent the generations falling further and further apart.

And I think if you're going to take this sort of approach, and I think it also reflects a lot of the discussion we've had with the big focus on health systems strengthening, we also need to be thinking beyond just diseases.

SANDRO GALEA: Just a quick comment on that. The group discussed that, which is actually why we put the advocacy and foundational issues up front. We discussed whether or not Just a quick comment on that. The group discussed that, which is actually why we put the advocacy and foundational issues up front. We discussed whether or not you can do a similar exercise to tackle particular foundational determiners. We

actually thought you could, but we thought we could not in the time given to us.

ALASTAIR AGER: John. So, question here, Kenneth.

KENNETH CARMARGO, JR.: I didn't understand the difference that you made between treatment and care because –

SANDRO GALEA: Perhaps the difference is best understood with something like Alzheimer's where by treatment, we mean are there medications, medical approaches to mitigate the progression of Alzheimer's. The answer is relatively few, still. Care is system-wide care of people with the disease which plays out quite differently in some of them, for example, Alzheimer's. That's what we meant.

ALASTAIR AGER: Okay, thanks, Sandro. I want to move on to Group Two. Pierre is the rapporteur for there. The presentation or the PowerPoint for that group will hopefully appear on the screen in just a moment. There we go. Let me – yeah, there we go.

PIERRE BUEKENS: Alright, let me try to summarize the discussions of the group. There was a lot of emphasis on globalizing global health, not creating new silos. Not dividing non-communicable and infectious diseases, taking into account the greater contextual complexity of the world and health issues and the changing self-perception risks, the big differences in addressing malnutrition and obesity for example.

There were a lot of discussions on metrics. I mean, if we want to know what the problem is, we have to be able to measure it accurately and it seems that we have not made a lot of progress. We need to have standardized global metrics including for the US, and there were good discussions about demographic and health surveys, and the need for DHS in the US, which is, I think, a very good point to re-globalize the process.

And then when we analyze the data, we should emphasize the gaps rather than national averages which was a point made by our colleague from Peru. So this is about what? Not having silos, not trying to chub the issues too much, and trying to keep having new metrics which are also relevant for the US.

What about the who? We felt that too much, we are pushing the issues to the individuals while the role of the state, the society, including the private sector, should be re-emphasized. So we want to kind of go back to our roots where the state and the society had more role perhaps than the individuals in tackling these issues.

We want to involve all layers of the society, including of course, the individuals. We want to involve all players. And we have to acknowledge the fact that many of the players already are playing a key role in public health, even if they don't know it. So we have to recognize their role.

And then we need to – and then we convert with the first group, we need to have a highly trained global health professionals workforce and advocates both in the north and the south and really emphasize the fact that we need, in the north, to have the appropriate training, but also in the south when colleagues from the south come to the north and help us to solve also our problems. They have good understanding of the health system, the north. So again, a push for globalizing global health.

And, how to do this? Well again, by moving away from north south and tap down approaches, by having a new global approach to advocacy, by emphasizing social justice and education. So you can see in the discussion, I think there was always this – on the one hand, this emphasis on really trying to globalize, but on also going back to our roots, and of moral and of the state, and more emphasis on social justice and education.

And then we believe it's important to build local capacity for research measurement of elevation and advocacy globally, including in the US where the research side is very strong, the measurement is kind of okay, and the evaluation is kind of shaky, perhaps compared to what's happening in many other countries. So we want to globalize that approach.

Any other points from the group?

ALASTAIR AGER: Thanks, Pierre. Yes, any point from Group Two or from Group One who would work in a similar issue or indeed throughout the whole? Just show your hand. Any comments? Do you want to just take the microphone, sorry?

BETSY WILLIAMS: Betsy Williams. I think, we talked about it yesterday about the linkage between the global and the local and it struck me that in both of your slides, you really linked it back. And I think it's something that we have maybe not spoken enough about, is really how the global isn't just the health needs elsewhere, but really, it's just as much here and in France. And so anyway, I just wanted to say thank you for highlighting that.

ALASTAIR AGER: Thank you, Betsy.

PIERRE BUEKENS: You have to thank the group, I'm just the rapportuer.

ALASTAIR AGER: Okay. [Laughter] Do you want to take the microphone from here, Sonia and then Jerry?

SONIA CORREA: Thank you for that presentation. Just within the context of your reference to the US demographic health surveys, I think it's important to point out that there are many instruments which are supported by multilateral and bilateral institutions which have been institutionalized in many developing countries. So there is the United States support, USCID supported demographic health survey. The Well

Bank supports the social and living standards measurement surveys in more than about 80 countries. And UNICEF supports the multiple indicator cluster survey system, and all of these are population based instruments.

So within the context of changing health and prevention needs and the need to institutionalize a mechanism for getting population based risk factor data on non-communicable diseases, it is important to explore how the scope of these instruments can be expanded because there's a lot of refraction is at the country level to expand the scope and this could be something that could be pursued at the global health level.

PIERRE BUEKENS: Sure, I think DHS was just one example of a survey which is happening in many, many countries and not in the US and if we want to be able to have a global approach, we need to have data collection systems which are worldwide, not excluding one side. And we will dream in the US to have many of the data you can find in many other countries of the world, so that is also part of globalization. So that was the point, I think.

ALASTAIR AGER: Okay, Jerry, then Hassan and then we'll move on.

JERRY COOVADIA: Question: What exactly will global health professionals do? What will be their day job? I mean, I'm not clear so there must have been something in your

discussion which describes the sort of roles and functions of global health professionals.

PIERRE BUEKENS: I think the premise here is that global health is public health.

JERRY COOVADIA: Okay.

PIERRE BUEKENS: I'm biased of course. And so you want to have a public health workforce which has a very, very strong understanding of the affairs of the globe. So they can run health programs around the globe. Now that's one approach. You can also say that beyond public health, the globalization of training for all health professionals will help our agenda. And they can also participate in meetings like this.

[Laughter]

JERRY COOVADIA: Thanks. So it's not setting up new departments of global health with professors of global health and lecturers, you know, the whole paraphernalia of a new department which will be costly. It's not that what you envisaged.

PIERRE BUEKENS: Well, I have a conflict because I'm here as rapporteur. So as rapporteur, we did not discuss this. Personally, I think that indeed we shouldn't create completely new entities, but rather globalize what we have. Globalize very actively, and really globalize. Not only trying to be more international, but really linking the two and that's why

this example about DHS surveys and so on I think are really telling of the challenge we have ahead of us. But this is my opinion, not the opinion of the group.

JERRY COOVADIA: Thank you.

ALASTAIR AGER: So Hassan and then we need to move on.

HASSAN MSHINDA: Yes, my comment is regarding the measurements. I think we should also give space for understanding what are the innovations or initiatives which are happening at the country level. For example, on the measurements, you have demographics on violence which are existing in many countries and [inaudible]. Because this, you do not find in any textbook. You do not find it in any — there's no any agency knows that. There is no big expert from the north, no understanding demographics of violence. So you find it is somehow hiding. It's not getting its own profile.

The second issue is on the DHS. The story of DHS is very trusted because you hear that DHS is highly promoted. And if you look at it critically, is a very small sample size and it is well regarded by all the experts in the world. And what you find, what is interesting is the analysis which is coming, which basically, the countries are involved in data collection. The descriptive analysis is done in US, and there's no secondary analysis which is being done. For example, I'm in from Tanzania. The DHS Servicia was funded by the Tanzanian

government, but when they want to, my researchers, our scientists to do secondary analysis, I had to request macro to do that.

And second, then the sad thing is also that the [inaudible] thing is that you find some secondary analysis has already been started to be done by other scientists who are closer to develop by development agencies and our scientists are just looking, they are just waiting for those results. I think this is one thing which we need to change.

ALASTAIR AGER: Thank you, Hassan. We do need to move on to Group Three. Pierre, thanks very much. Renuka, Group Three. Can we have the slides from Group Three please?

RENUKA GADDE: Okay, Group Three, we were facilitated by Jennifer. It was a great discussion. Several points trying to condense that into three slides. So group members, please feel free to chime in should I be not representing a point of view here.

But under the what section, our group strongly felt there were two things that emerge in what, which is having an interdisciplinary approach to global health and all to demonstrate the collective value of global health. What we meant by that is to look not just within public health, but outside public health when you're talking about engaging technology development. Working with multidisciplinary folks

such as the engineers, the engineering schools, if you will, and really using the game changing technology of information technology networks for education and management which is being done to some extent today, but we felt strongly that that would revolutionalize the whole approach.

Document the collective value of global health, I think there was much discussion to say we need to demonstrate an evidence-based value of global health that can incentivise why someone should invest in innovation and technology in this area. And the way to do that was to again, link this by demonstrating the value with security, with diplomacy, with economic benefit and impact.

Again, back to the same theme about engaging cross disciplines was working with the agricultural energy food security sectors because without question, rural electricity transformed health systems here in the United States and not to forget the learnings and use that learning as you're moving forward to the broader global health agenda.

The final point under the what was not just to insure that there is rapid diagnostic technology or rapid technologies, but also to insure that there's uptake of these technologies working really across the biotechnology and other technology segments.

That was broadly the what. If the group felt something was missing, now is the time to add.

So when we looked at the who, with that question, the group discussed that we had key stakeholders, ministries of finance education, health diplomats, ministries of education, civil society, but I think Peter termed that very well to say well, we really need to be engaging smart coalitions. It's not about addressing, it's about going country by country, need by need and engaging smart coalitions and new alliances which can involve entrepreneurs, activists, security leaders, diplomats, military, defense that came out as a big team, particularly when you're looking at what we're doing in Afghanistan, economists, secular and non-secular actors, faith-based religious groups, private sector, the academics researchers, community leaders and civil society.

But we specifically called out the ministry of finance as not just part of the smart coalition, but as a bullet point here almost to say the very key, even if they don’t have funding to be engaged in the process as they do influence the whole program and the policy. We said policy makers across sectors, again not just leaving it to the international agencies, development partners and donors, stake holders and intellectual property trade agreements, a key role for private sector and social entrepreneurs, scientists and researchers,

but also finally actual technology users, we felt need to be part of this. In a way you can say all of this is part of a smart coalition.

How, and I think this is where Jack came back to say — oh, these are the wrong slides. Alright.

ALASTAIR AGER: You need to be emphasizing the role to the private sector. We emphasize a lot the role of the private sector in public health, in global health and in innovation and technology in contrast to what some people say.

RENUKA GADDE: Right. So we couldn't agree more with that. On the how, I think Jack said let's not look at the same old, but let's look at some bold mechanisms for how, and the suggestion here was to almost create a fund for science and technology, like a global fund that provides tax advantages, engages public, private and universities, insures IP transfer, and engages in local research, a thing that came up in Group Two as well.

So that was really kind of a bold idea, entering incentives and structures for innovation and technology development and uptake. Facilitating south to north learning and innovation used through an integrated mechanism came up quite a few times in the discussion. And really, we were looking at getting some of the reverse technologies back here, not just look at north to south, but south to north.

Engaging in new platforms for knowledge exchange, but also creating university reward structures to encourage interdisciplinary collaborations which was felt doesn't happen that much today. Using existing technologies to create networks and databases that will have an impact on global health. So that's kind of the high level summary of how.

ALASTAIR AGER: Thank you, Renuka. Questions or comments? Rohit?

ROHIT RAMASWAMY: Yeah, I was a little curious about your first slide. Were you really talking about – can we go back to that first slide?

ALASTAIR AGER: I'll try to. Can we have the slide set back, please.

ROHIT RAMASWAMY: The third bullet which says – are these the right slides? Okay. The third bullet which says documenting the collective value of global health as a way to incentivise innovation technology. I'm curious about what you meant by that because it seems like that's a backward process. I mean, if you're really thinking about the innovation diffusion process, innovation kind of precedes, because that is a need and innovation fills that need. So it seems to me that if you want to be able to have innovations in technology, the – kind of a need gets established and innovations occur as a result of that.

So if you have to document the value of global health as a way of getting people to innovate, seems like we're going backwards about this process. I was just curious about that.

ALASTAIR AGER: Let's have a couple of comments and then a response from the group.

ALASTAIR AGER: Yeah, just to respond to that. I think that when we mentioned the documenting collective value, we really meant for other sectors. We meant for economic development, we meant for security, global security and health diplomacy, we meant for innovation. So it was much broader than just innovation technology. We see that global health has been energized, at least in the United States, by pitching it to the development agencies, by pitching it as an effort for global security, a fight against terrorism, all of these things and that we shouldn't lose that vision. So we really have to document the value.

And I also want to highlight that the idea of the educational value, that for the long term, investments in people and local research is absolutely key to the sustainability of these efforts and some of what we do for the what should be to empower local investigators with research funds and to promote their projects so that this agenda can move ahead.

ALASTAIR AGER: Okay, I'm afraid we need to go to Group Four. Sorry that there's a couple of questions there. Hopefully we'll have opportunity later, early this afternoon, to very much drill down even further to this. Thomas.

THOMAS COOK: In Group Four, we covered some of the same topics as Group Three. I'll try not to be too redundant. Our overarching concern here was with building self-sustaining equitable capacity for innovation and technology, not just in the north, but in developing countries as well with the goal of creating the next generation of public health scientists, providing leadership in science and technology. And as with, I think, every group so far, ICT or information technology is seen as a really important player or approach to doing this.

Our bottom dash there about innovations and uptake translation et cetera, I'll just mention a couple of those. There was discussion about the, certainly, translation and that is taking existing interventions and existing knowledge and disseminating it, translating it, whatever the current buzz word might be, but basically to implement proven technologies. This is what, you know, for a long time, WHO called the know-do gap. We know what causes many diseases, know what should be done to intervene, we just have to do it.

And then validation referred to validating new technologies, and I think this has been mentioned before, not

just to chase a new idea because it sounds good, but to actually evaluate and validate whether or not it is effective. And then the idea at the bottom there, the bottom bullet about needed by both north and south, this is the two-way street that I think's been mentioned a number of times in terms of innovations that can go both ways between the north and south.

When we got to the who part, Pat read a list of all the possible players and the unanimous answer was yes in terms of advocates, government, private sector, scientists, civil society and so on. We were in agreement that to implement some of these strategies really requires support from all areas, but also recognizing the need for what we called a local champion, someone upon each specific topic area to really be the passionate leader, to put forward the science and technology related to a particular topic whether it's AIDS or clean water or whatever it might be.

And how to develop this local leadership, of course, is a challenge. I think Roger mentioned the real need for developing local expertise or in-country expertise. We were fortunate to have Derek involved in our group, so talked a good bit about the private sector and how to include the private sector in this whole process.

And then let's go to the how slide. We had a good bit of our discussion, I think, fell under this category. Things

like the need to align short-term and long-term goals. I think we've heard about this before in terms of solving immediate problems, but still looking at long-term capacity building. The need for some sort of the best – one of the terms we came up with was framework. Some body, some unifying organization that could be the buffer between outside funders and other groups that have an agenda and the local needs.

And the idea of a body for example like the Institute of Medicine or the Africa Academy of Sciences, or someone that the local people could gain credibility from and say yes, this is a priority, yes, this is not a priority in terms of someone who has an externally derived agenda for where resources should go. The idea that funding needs to address a capacity building, again, this is a long-term verses short-term, and not just immediate projects. There's our greater use of ICT again in terms of enhancing communications, our concept again about local championing, leadership and local priority setting and local buy-in to what the priorities are. And I guess I'll stop at that point and entertain – any of my cohorts have anything to add?

ALASTAIR AGER: Thank you, Thomas. And just general comments or questions from the floor in terms of that? Miguel? Just take a microphone from behind. If you also have a

question, you can just show your hand. I can make sure they get a mic for you.

MIGUEL GONZALEZ-BLOCK: Thank you. I would like to ask both Groups Three and Four on discussions you may have had to strengthen the innovations on the management and health systems side of the equation which would be innovations that can provide for the context for a hard technology to be scaled up and implemented. I didn't see any distinction as to the importance of public private partnerships, private development partnerships modeled on that approach, especially based in developing countries where that innovation can indeed be best undertaken. Thank you very much.

ALASTAIR AGER: Thank you, Miguel. Can I just take any other questions for the group? Ayman?

AYMAN EL-MOHANDES: Group Three mentioned the ministry of finance as a partner in this, but sometimes, one is lost in the economic analyses and their relevance to implementation. There isn't enough of comparative cost analyses to different approaches and also related to workforce shifts in developing economies where that can drive the cost down significantly. And we, I think, in my humble opinion, we need more of that to further practice.

ALASTAIR AGER: Thank you, Ayman. Any comments from Three or Four before we move on? Sorry.

THOMAS COOK: Can I just mention we did talk about the management skills in terms of managing resource projects or managing innovation. I guess that we didn't actually get the word management on the slide here. But I think in terms of developing local capacity, local leadership, we definitely talked about the need for project management skills. And I think for many of us, that's been a real necessity in some of the work we do, to try to develop research capacity.

ALASTAIR AGER: Was there any comment back from Group Three on that? I was just checking. Okay, we'll need to move on to Group Five. Oh, sorry.

JENNIFER HIRSCH: Is this on? Yes. We did have the word management on our slides, or at least on the version of the slides that we finished, and I think Miguel your point is existing forms of information that exist in public health that need to be applied. Including, I mean, I would say that [inaudible] having the word management, the idea of using existing bodies of science, including management, was something that we talked about.

ALASTAIR AGER: Okay, can we go to Group Five? I think that's right. And the facilitator? Miguel? I'm sorry.

ROBERT CARR: Okay. So our group, we reorganized our presentation slightly, so we began with the how. Um, we felt that a very important way of proceeding on the issues of

globalization and governance which was our topic, was a sort of overarching principle of human rights and ethics. Bearing in mind that governance is a process from information gathering and analysis to issuing of directives, that it was important to identify priorities and effective frameworks.

Monitoring and surveillance in relation to accountability are also crucial and building capacity at national level for delivery, not only in terms of health systems, but also in terms of some of the other bugbears, for example, services for excluded populations or populations who often don't access health services for different reasons.

Insuring transparency and adherence to principles of participation, we'll come back to that later, and then some key questions that we didn't have a chance to resolve, is accountability for what and the point that the emergent governor's processes need to build on excitement and increased funding to make them actually work so we can move from ideas to action. Next slide please.

So then what. Globally, we need a good platform. But we, again, we were discussing to what end. And one of the key tensions is we need to have an opportunity to talk to each other, but the question is, should that global body have to be a governance body and therefore have the authority of the governance body? Or should it be a convening mechanism? And

this is a tension that we weren't able to resolve in the time that we had or propose a resolution for.

But we did think about the importance of WHO in terms of setting norms, standards and guidelines for good practice for monitoring and surveillance, and for reporting. And inside of that also is a need to commit to evidence-based responses. It's come up a couple of times, the issues of secular approaches as opposed to other kinds of more partisan approaches and the importance of moving forward on evidence based policies. So that's also behind that comment. And then the need to learn from and strengthen existing regional and global governance mechanisms, and we thought about Ghavi as an example and The Global Fund as an example.

Nationally, the importance of transforming existing platforms into more accountable and transparent mechanisms, again, we talked about the CCMs of The Global Fund. Although, for those of us who work in HIV, there are also issues with CCMs, but they do at least provide a new way of working and thinking about governance and public health at the national level.

And then as part of all the unanswered questions in there, the need for a research agenda on effective forms of accountability and on global public goods, goods there is a pun, of course, and bads on health. Next slide.

And then who, the importance of bringing together key players and again Ghavi and The Global Fund as an approach came up, and of course, the central rule of government. The importance of civil society, although need to sort of break down who we mean by civil society, and consider the plurality of actives and we've put some there. The importance of academics and then other key players.

ALASTAIR AGER: Thank you, Robert. Comments and questions from other groups? Yes, there's a question just there.

FEMALE SPEAKER: I just wanted to comment on, I think it's interesting how you mentioned a platform for governance or convening and accountability because it’s something that I've been wanting to throw out there since yesterday is the recently proposed Framework Convention on Global Health. And there has been talk of having more legal accountability mechanism for governments to commit to global health. And it's just something of course there are a lot of challenges to that, but it would carry global health from a moral obligation to a more legal obligation on governments.

ALASTAIR AGER: Christina.

CHRISTINA ZAROWSKY: Thanks. I just, I'm always torn between being an anarchist and a socialist in these kinds of venues and, you know, very mindful of the whole tea party

movement here and what does it mean to – we have this public health drive to shut down restaurants and so forth and how do we recognize and move on that in a way that makes sense and yet doesn't evoke Stalinist images in the rest of the world including ourselves.

The recurring theme around secular verses anti-secular, I think is an important issue. We are not non-aligned and we are not neutral. There was a meeting on public health and population in Canada where another Stephen Lewis pointed out that population health and public health is essentially a social democratic concept and not everyone is a social democrat. So how can we become more explicit about our value systems and make that a legitimate terrain? So can we discuss and debate values and preferences as well as the evidence in support of them or against them?

ALASTAIR AGER: Jerry, just behind you.

JERRY COOVADIA: I want to ask about that first sentence you put up which is what we have also put up, that one of the guiding principles is human rights, right? And ethics. Now as I said we believe in it also, our group has got it somewhere. But my concern is if you make it number one, priority number one, I mean, you'd be involved in a whole lot of issues which effect [inaudible]. I mean every despot, every conflict, every war, every major piece of international

corruption, the role of corporations which might be involved in that. You know, I mean you could go on and on, so there must be some limits which don't dilute the effect on health. I was wondering whether you considered that?

ALASTAIR AGER: Brief comment, Robert, from you, but then we're going to Group Six.

ROBERT CARR: I don't think we considered it from the [inaudible]. We did think of the importance of human rights for the reasons that our colleague just mentioned about, you know, approaches that are sort of anti certain populations or anti certain approaches that are clearly are important for improving peoples lives.

But you know, for us, we were really thinking about what are some of the fundamental principles that we can use that can undergird what we do. And we were also thinking about how that operates at the global level and at the national level. So some of what you talked about would be more appropriate for global level structures to be dealing with.

But if you're talking about conflict for example inside of countries, or even we talked about sort of across border issues, right, across border health issues. And we also talked about displaced persons, refugees, mobile populations, and so on. That's why we thought there was a need also for the regional level, although we didn't name it in our group

discussion, that there needs to be some opportunity for sort of cross border discussion about norms and standards and obligations.

But again, I mean, this comes back to the issue of what's the function of that global level? I mean, is it a convening function, in which case we all come around a table, or is there some kind of jurisdiction? Are there some kind of consequences for breaches?

It does take us into the complicated world of human rights generally and how are human rights enforced, especially as all of that is being eroded. But we didn't feel that there was a way — we didn't want to move away from that grounding in human rights as a fundamental principle of moving forward.

ALASTAIR AGER: Yes? Okay, thank you. Gita, can I ask you be very brief and we're going to go straight to Group Six.

GITA SEN: Yeah. No, it's just a quick response. We, this is part of the how, so it's as a principle for how. It's not the what. So it's not the answer to, you know, how wide you cast your net or how narrowly you cast it. It's wherever you're casting your net, the how is what this is referring to.

ALASTAIR AGER: Thank you, Gita. Sabina is reporting back for Group Six, also looking at the propositional questions around globalization and global health governance, which is here.

SABINA FAIZ RASHID: Okay. So our group talked for a long time on the need for a new vision because there is a changing landscape. There's various institutional structures, agencies, actors who have played a role, play a role, but there's also new agents, change-makers who are influential. And what do we mean by global public health governance? There were some discussions on, there are these structures and actors, but the current governance structures, there's no accountability or a lack of transparency, or even – there's some accountability, there's also an absence of accountability.

And we're not clear about the roles and functions of the various players. And given that there are new players who do impact on policy and decision-making, but are not bound by, let's say, some of the governing structures that we talk about, or various groups talk about. It's sort of outside the control in terms of talking about global health governance.

There was some discussion of even when you talk about a global health governance, an example we drew from Gita Sen's [inaudible] talked about trade agreements which enforce countries to follow certain policies which may go against basic good public health principles or may impact on public health, good public health decisions.

We also talked about where the voice is from below and within to challenge some of the, let's say the structures in

place which do not necessarily have to report or account to anyone. So we talked about mapping this disconnect between the location of power and who exercises it and trying to understand who are the players?

And some of this is global, national, the blurring of between groups and countries within and between. We also talked about, you've got certain obligations on states. There's this paradox where states have to fulfill certain legal obligations, but hey don't necessarily have the ability to do so. For example, you know, if they need to, you know have a lifesaving medication available to their populations, but you have actors within that country or companies or corporations that do not have the legal obligations, but do not fulfill these roles and responsibilities.

So how do we – who do we need to engage with? We need to engage with organizations like WHO that do play an important role, but there's other actors increasingly taking over these roles and responsibilities. We also talked about, so engaging and defining new roles and also working with stake holders who are not just ministries of health, but looking at it across sectors, you know, talking to influential leaders or champions across different disciplines. And this is within the global community, but also at the national level. So communities from the bottom, not just the top down approach.

We talked also a lot about the role of the private sector. Often there is enough discussions in health systems of policies engaging with the private sector and other actors who are influential to communities and populations. Actors in the traditional and formal systems or even the role of the media or journalists who can play a strong role in advocacy or influencing policy.

We talked a little bit about local health watch groups that exist in some countries and how to engage with them in some ways facilitate by providing new approaches to information. You know, right information is extremely important if you want build advocacy or create strategies for working on certain health areas, the need for transparency and understanding what needs to be changed.

And how do we do it? Well, we've laid out a whole system where we – it goes back to our first slide where we talked about a need to really understand and document the dynamics of governance processes because there really isn't much empirical research on understanding how do these processes work. How do players play a role, how are decisions made? How are policies made? And that's where you can track the accountability and also understand some of the policy processes.

We need to try and understand. And I think there was also a recognition of global players need to work more with or share visions and missions with civil society, deconstructing what civil society is and who they are. And it's important to show the interconnectedness of public health with other sectors, a point that's been taken up over and over again with the other Groups. And show the impact, the how do you buy ownership?

You talk about the economic impact, the social impact, so public health is wider and it also impacts on your sector in your area. Some of that's already been said. We want to look at using policy opportunities. Forums, dialogues, meetings, discussions in very strategic ways in terms of moving forward certain agendas and forums and dialogues often are useful working with different actors.

There was some discussion about placing regulatory framework so even if it's in place, how do we enforce it? How do we insure that some of that is taking place at the national or global level? Thank you.

ALASTAIR AGER: Thank you, Sabina.

SABINA FAIZ RASHID: And if there's anything else –

ALASTAIR AGER: Comments or questions from any of the Groups? Yes? Just here. Sir, could you pass the microphone please? Thank you, Carol.

SANIA NISHTAR: Thank you very much. I'm just interested in what looks very transformational on your first slide, the what slide relating to – one back – relating to power. I think for me, that's very transformational, the second bullet from the bottom, the disconnect between the location of power and who exercises it. And I'd appreciate if you could just share a little more of your discussion on that.

ALASTAIR AGER: Could I just have, are there any other comment for this group? Okay, let – not necessarily Sabina, it can be Sabina, anyone in the group, just to come back to that? Lynn.

LYNN FREEDMAN: Some of the discussion that went behind that was looking at the fact that the human rights regime really puts the obligation in nation states, primarily. But in the globalized world that we're talking about, very often the power to meet the obligations is not within the control of the state and is with many other actors who actually have no legal obligations. So the disconnect between where the obligation is and where the power to meet it is.

ALASTAIR AGER: Thank you, Lynn. Can I come to Group Seven and Franciso?

FRANCISO BASTOS: Hi. I will be close to the screen. First of all, we tried to address the what in terms of what [inaudible] cross-cutting themes and values and strategies.

This is a way to understand our reach in terms of our process and not in terms of a snapshot, so basically, different countries and different societies are trying to reach the goal in terms of broad coverage.

It's a necessary step, a sufficient step in terms of equity, but it's very complicated to obtain this in any place in the world. But in terms of the bottlenecks and barriers, they defer model between different societies. So for instance, in terms of African countries, we have brain-drain, we have immigration, low salaries and so human resource shortage is a very key issue, and also the management of the workforce.

And another question is the regressive health financing is toward a more equitable distribution of contributions and the deliver of service? Another thing is that you can have the things in place, but you can't lack political will or you can face barriers posed by politics and culture. A lot of stuff is that many health systems worldwide are very fragmentated and they have no comprehensive interlink between the different sectors and institution and actors. And we prefer to use the concept of non-state sector to include both profit and non-profit private sectors and many times, it's complicated to integrate both the sectors with the public.

Another thing is that this pervasive manic different context is malpractice and corruption in health system. So is

a diversion of scar resource into other priorities or just a diversion of scar resource for private people for individuals or groups or any stuff. And a lack of framework to compare accountability.

So I am — our idea in terms of this first group of items is that even a country as rich as and powerful as the US is implementing the health reform in steps and so much probably all in 2014, the current health reform in the US will take place. So it's complicated to implement health reform anywhere in the world. Of course, much more complicated in poorer societies.

Some themes that concern everybody and everywhere, and we highlighted gender equity and the need to empower people. The rule of communities, equity and human rights. And in terms of strategies and intervention, I think universal coverage is a very important goal, but of course, it doesn't mean that you have equity guaranteed by the fact that you have universal coverage.

And unfortunately, some systems where universal coverage does exist, for instance, Brazil, we know that some areas are very equitable and the services are affordable, for instance AIDS. In others, they don't function well unfortunately.

The second is the empowerment of community, especially vulnerable populations. Another thing is that many times we have different partners, but the don't work in a harmonized way, so they have conflicting agendas and this could duplicate the cost increase. The conflicts between different agendas, institutions, individuals. So it's necessary to harmonize and to align these different institutions and to invest in capacity building in terms of individuals, institutions, and networks.

And to mobilize people with energy, passion. That is something that can happen and it's just a matter to channel some energies to health. For instance, if we had the same commitment we had when the world helped Haiti to face earthquake, that now they are facing a serious epidemic of cholera, it will be very, very important. But unfortunately, it is not common. People many times are committed about metro disasters and then consequence, a health disaster like they are facing now, we have much less media attention and much less awareness from different people.

And finally the need to scale up successful initiatives. Basically, not to repeat everything, I think the main issue is not to exclude any of the partners currently involved in public health, but basically to include people who are now voiceless. And in this sense, it's very important to include the consumers, to heed the opinion of consumers,

vulnerable populations. And another thing we discussed is to try to string and to renew the whole of the different UN agencies that are very important agencies, but have a very bureaucratic structure and the world is changing fast, so we need to adapt these agencies to the current needs.

And so we call the people who should matter, but are not heard. What we call these, the missing voices. So many different strata like women, the people who advocate for human rights, but also the institutions who are very powerful, but not always committed with global health like the financial institutions and the media.

And it's – oh, okay. No, it's okay. I'm talking too much. So capture hearts and minds, more or less the same. Empower the local system leadership. Align the global institutions with agendas. Engage and empower communities and leverage new technology and markets.

This was mentioned by Peter Peul is something that I saw functioning very well in Brazil when we had a campaign against Swine Flu and Brazil had one of the highest coverage in the world. And one of the strategies was to mobilize young people that are normally the people who are most difficult to reach because they don’t feel themselves vulnerable and I saw many people being reached by clever advertisement and also MSN message delivered to the mobile phones.

Now everybody in the whole world have mobile phones, exception, myself. Okay. I think it's finished.

ALASTAIR AGER: Okay, thank you Franciso. Can we have questions or comments for Group Seven? Any observations in the room? Sorry, is the one – I'm being blind. Please, help yourself. Thank you.

MALE SPEAKER: Thanks. That was terrific. Just one question, what is a health system? What are the boundaries of it? I noticed that you didn't call it a health care system.

FRANCISO BASTOS: My point of view, I don't know if the group does agree with me, but I think we could think about a health delivery system that's something specifically linked to delivery of concrete service for your people. Then you can add another layer that is prevention and promotion of health and another layer that is the whole intelligence in terms of surveillance and management of the system. So, this is the way I see myself. Maybe it's not the opinion of other people, but I see that besides the delivery of care you can think about these other two structures. Actually what we see many times is that sometimes you have very, very good health facilities but managed, in terms as a network, functioning very badly. So referral is low and it doesn't function. What people don't want to send patients to other sectors or other facilities, so this is my point of view.

ALASTAIR AGER: Okay. I think we need to go to group eight in our final group. Thank you.

FEMALE SPEAKER: Thank you. Group eight spent a considerable time discussing this, but essentially the issue around health systems really needs to be recognized as complex adaptive systems that are in need of strengthening to achieve global public health goals, and it was with that in mind that we did our work. I think the other over-arching issue for us was to focus on the health equity part of it and to recognize that this had to be grounded in the human rights, and the human right to have a specific laid out in the chart of human rights and in Alma Ata, and that that would be a value system that health systems would have to hold as their way of moving forward and that it was now perfect. However, to go on to the what. The what really is to focus—

ALASTAIR AGER: Sorry. Go back please.

FEMALE SPEAKER: Go back please to what— So, the focus on primary health care approaches and primary health care as defined by Alma Ata, population outcomes are also included in that and we would focus on prevention and social determinacy of health, and in that way the human rights needs would, to some extent, be accounted for.

Clearly it would need adequate financing as far as human resources and stewardship management was concerned, and

the financing would also have to have a poet [misspelled?] for capacity building and training, and to recognize that there is a shift towards chronic disease care and that this would probably mean a change in some of the power dimes [misspelled?] of which people work.

But the what also will include a future focus and a recognition that, not only were the rules of the consumers, patients, citizens, etc. changing and that with the rights base approach we would want that to change, but we also would have to have a future focus in terms of what might be coming down the road in terms of, for want of a better word, an epidemic.

There are issues that are happening globally that we would have to be prepared for, and so there needs to be a part of the system that really is focused on looking at future organization of things. The how, recognizing that health systems are complex as we said, and that the work of the academics would be a fact in trying to synthesize ways of moving from local to global systems that work and to support in the academic work, the development of local and national systems.

Lesson learning, benchmarking and standards, and integrated models would have to be part of this learning. That statement about regulated private sector involvement within a public governance of health I think is important because it

really means that not only is the public sector recognized as a player, but that the public governance of health has to be involved in the regulation of the activities so that they don't just go off on their own and do whatever they want, which may not necessarily be in the public interest. We need to develop the science of scaling out systems because we have lots of best practice activities around and lots of pilot schemes that work, but there is quite often a big gap between translating best practice on a small local project to a national project that works and this need for full development of the science around how that is done.

And, of course this need to develop models of sustainable finance and so that the research activity in the public health system strengthening has got to be not just in health, but also in the envy [misspelled?] mechanisms for supporting health in financial and in the social sciences aspects of things. And finally, the who. Who is really everyone. Governments working from local to national, regional networks, and the setting of regional standards and mechanisms for those standards to be implemented locally and globally, and again the communities, the consumers, the public and private providers, and not least the global public health community. And included in that community are all the non-governmental non-state players. Thank you.

ALASTAIR AGER: Thank you so– [Applause] Any comments or queries for group eight before we transition? Les? There should be a microphone near you somewhere. There you go.

LESLIE F. ROBERTS: Thank you. [Inaudible] I was trained as an engineer and I liked a lot of things about what you just said, but what I liked very most is that you used the word systems in the way, in engineering school, I was taught it was: A body of things that add up to some outcome greater in total than the sum of the individual parts, and I just loved that as you talked about systems, it was inseparable from the measurement of outcomes. Whether you were talking about scaling up, so that was just a comment of thanks.

ALASTAIR AGER: Thank you.

FEMALE SPEAKER: Thank you Les.

ALASTAIR AGER: Any other comments from groups or queries before we move on? Okay, well [inaudible].

WAFAA EL-SADR: Thank you Les, we worked very hard at that. We start with outcomes and work backwards. I just wanted to make a comment. I think which was touched on briefly by our group, but I heard from other groups, is this evolving sort of worrisome dichotomy between prevention and care; which I think is not very helpful from the perspective of global health to global public health. And, if we are thinking of outcomes, then really prevention and treatment and care are

together and people don't just have a treatment need and then they have a separate prevention need.

Communities have both intermeshed together and I worry that, I heard it several times maybe sort of over the past day and a half is that it appears that we are saying, well if we are interested in public health, we are only interested in prevention," which I think is maybe a limited way of thinking of the health of populations. We have a lot as public health community to inform the construction of the health system to achieve the outcomes desired, irrespective of the processes and the inputs and the outputs. Thank you.

ALASTAIR AGER: Thank you [inaudible]. Christina, and then perhaps one other comment and then we will move on. Is anyone in the hole?

CHRISTINA ZAROWSKY: Thanks. I mean, I think that there's a lot of code in a lot of the slides because it was trying to squish brainstorming into a couple of presentations, but just that there was an earlier question about what is a health system. I think that this does come back to one of the points in our discussion was that its health systems is not synonyms with health services. We really are following on an Alma Ata vision of primary health care and a WHO definition, and in that regard the chronic disease shift is kind of code for, let's think about things like the FCTC or tobacco control,

which absolutely have to look inter-sexually, what's the role or what are the roles of the health sector in a context is much broader. That isn't, you know, you don't stop treating chronic obstructive pulmonary disease just because you've banned tobacco advertising.

ALASTAIR AGER: So, Joseph Harrison and then we'll move on.

JOSEPH MFUTSO-BENGO: I was [inaudible] scaling out. Do you— I just wonder because I see the scaling up of, what do you call, best practices have to do again with power and I don't know how you meant by science. Do you mean that it's either science or implementation? How can we manage to scale up best practices even with those people who do not have power? Because we [inaudible] means that the one who has good code can determine this [inaudible]. So, the scaling up of [inaudible] of treatment, but also best practices, how can it be done when the [inaudible] what do you mean by the science?

ALASTAIR AGER: Harrison.

HARRISON SPENCER: Thank you. I just wanted to strongly support what Waafa said. We hired a firm to talk about how we could do a better job of communicating about public health some years ago and the first thing they said is "you people talk about populations when what people what really care about, first of all, is their own health and second of

all, the health of their families." And so, if you're only talking about the populations over here, they see a huge disconnect.

Secondly, it's not a good way to think about health anyway. I also think, by the way, that it's something that's very different depending on where we're from and in this country we're spending a lot of time trying to connect up primary care and public health because a lot of— with the epidemic of chronic diseases, those diseases are going to be managed and treated mostly in the communities anyway, and then the public health workers become a strong part of the team, but I think this is something extraordinarily important and something I think quite difficult, depending on where we're from because everybody's got a different idea of what it means.

ALASTAIR AGER: I want to transition just to introduce Richard's little presentation to us before lunch and we have lots still of what's, how's, and who's and the purpose this afternoon, the focus this afternoon is very much to acknowledge that that's a massive agenda. And, there may be some interest when I get traction on some of those key issues in particular ways. And, we are very open to thinking about ways of doing that, of encouraging you to do it, or encouraging collective action, and one potential way which we were thinking about, is in terms of a notion of knowledge networks around some of these

issues. We are very much open to many other ways of doing it, but Richard is going to make a short presentation fitting in with the document that was in the conference pack, and then we'll have a short discussion on this before lunch. Richard.

RICHARD PARKER: Thanks. Could I have the slides? All right, they're there. Thank you. In short will be the key word here, partly because today this is what stands between you and lunch and that's never a good thing, but also because the background paper has already been circulated. What we didn't circulate to not fill up your inboxes, but what is online on the conference website, is a more extended bibliography and an annotated bibliography on knowledge networks for anybody who's interested in looking at them in more detail that were prepared by Dulcy Natividad [misspelled?] and Kirk Fyrick [misspelled?] from our group.

I just want to highlight a couple of points that were part of the background paper. There are many people here in the audience who have a good deal more experience with knowledge networks and knowledge about them than I do. My information technology guru Ken Kamargo [misspelled?] from Brazil, Gita Sen, who worked with the knowledge networks from the WHO commission.

In short, there are many of you who can, I'm sure, add into this discussion. One of the challenges coming out of the

planning meeting and that we certainly are still grappling with here today and many of the comments this morning have highlighted, is how to move forward from this meeting to something concrete that might come of it. That's a challenge that I think we all— we all go to lots of meetings and often then just end and they're over and we move on to whatever the next thing is that we need to do.

But, we'd like to have some outcomes from our time together here that might live beyond the two days we've spent together. One of the ideas that came up in the planning meeting that resonated with many of us and that we decided to explore and to discuss further in this meeting was the possibility of developing a knowledge network or some knowledge networks around some of these key thematic areas that we've been discussing for the past two days. There are a number of reasons why this in some ways, feels like a timely thing to do. We've been talking about shifts in paradigms and about the need for multidisciplinary approaches. We've been talking about the importance of trying to position public health within global health and to articulate more effectively what are the specific contributions that public health can offer to the field of global health.

We've talked a lot about the need to open up more broad-based discussions, build more broad-based and more

equitable partnerships, particularly between north and south, and we've talked about the need to stimulate participation of larger networks, more constituencies, more relevant stakeholders in these debates. In the age of a network society, as the sociologist Manual Castells describes it, in which the generation transmission and dissemination of knowledge is one of the key ways in which everything from economy to society works, knowledge networks have some very clear possibilities and advantages. Particularly given the fact that one of the aspects of globalization continues to be that even if it brings us closer in many ways, it also leaves profound divides including digital divides and knowledge divides that need to be addressed and confronted in meaningful ways.

Some of the kinds of things that we think knowledge networks can potentially contribute to include collective knowledge building. They can potentially help to create more open, more dynamic approaches within the field and to decentralize some of the kinds of control and power that have been more highly centralized than is good for the field. They can have a role in terms of linking people and really creating a more complicated and more open kind of social process around the construction of knowledge.

So, in the paper, and I'm not going to go into the details of it, if you've had the chance to read it that's great. If you haven't had the chance to read it, basically we just try to briefly review some different kinds of knowledge networks that may be well known or more or less known to different people in the room. The WHO Commission on the Social Determinacy of Health and the various knowledge networks that were linked to that commission is perhaps one of the examples that we know best in the field of global health, but there are certainly other kinds of knowledge networks like the Global Development Network of the World Bank that have been sponsored by intergovernmental agencies for example.

We also look at an example of the Global Urban Research Initiative which is more of an academic research knowledge network, as well as the South Asia Research Network which brings together academics with a more civil society, social movement kinds of organizations, and tried to give an example through those cases if you will, of the fact that these kinds of networks can be structured in quite different ways and that the kinds of organizations you want to involve, the kinds of actors who you want to bring to the table, are questions that are open for discussion and would need to be thought about if indeed we decide that this is something that's worth pursuing after this meeting comes to a close.

Some of the potential advantages that we see at least, but that we're certainly open to discussing and getting other ideas about, are the fact that knowledge networks potentially can be of relatively low cost. Not no cost, but relatively low cost way of being able to mobilize diverse perspectives, being able to create more democratized participation of stakeholders from a wide range of places and institutions and organizations. They can be useful in helping to break down boundaries between disciplines and to create the kind of interdisciplinary of multidisciplinary conversations that, I think we have fairly clear consensus, are worth having and they can be useful for creating and encouraging debate and thinking in new and different ways, even if innovation is perhaps over billed.

Thinking in new ways about old problems can sometimes be a useful exercise and through these kinds of networks that's one of the things that we think is potentially possible. It doesn't mean that it would be necessarily an easy thing to set up or carry forward. There are lots of things to think about in terms of how one might want to structure and what kinds of processes one might want to implement in organizing knowledge networks.

Some of the things that we highlighted in the paper, and they're probably not the only things, are what kind of vision does one have of what knowledge is and how it functions

and what it's overall purpose is. In thinking about any kind of network, as any of you who have been involved in networks know, issues of structure and governance are fundamental and if you don't address them upfront you're not likely to be very successful in moving forward and setting up that kind of undertaking. How to map out what a network would do and how it would function is something that requires some time and some thought. What kinds of information and communication technology tools one would need to work with. If we had the time, Ken was going to do a presentation talking specifically about that, different kinds of technologies that are better or worse suited to this kind of undertaking and how to sustain it financially.

As I said, it's not an undertaking that has huge costs, and one of the advantages is that because of information technology and the advances that have been made in information technology over the course of the past decade to decade and a half. We really do have the potential of developing these kinds of activities as much in the south as in the north, and that's one of the real beauties of this as a possibility. But, it does require some support and human resources as well as financial resources to be able to sustain it in a meaningful kind of way.

So, if we decide to pursue this coming out of this meeting, I think that those are issues that would need to be addressed. They're probably issues that can't be entirely sorted in a meeting of more than a hundred people and we would need to think about mechanisms, smaller working groups perhaps, that might be able to push forward on some of these kinds of issues and some of this kind of thinking, but what we wanted to do first in this session, and with a little bit of open discussion before lunch but then in more detail after lunch, what we wanted to do is open up a space to talk about this possibility and potentially any other possibilities that participants here might think are worth pursuing along these lines or in quite different ways than we might have imagined.

So, I think I'll stop there and really open it up for discussion and encourage a number of you who have spoken to me over the course of the past day and a half about ideas in relation to this, and so I hope you'll share some of that thinking with the group as well because we don't have a ready-made plan. What we're really trying to do is to see whether or not this resonates and if it's something that we might want to continue to think about together, moving forward from this meeting.

ALASTAIR AGER: Thank you, Richard. There's Derek here, and let's take a few observations then Miguel.

[Inaudible]

DEREK YACH: —it strikes me as frankly, kind of obvious, that this is the sort of thing [inaudible] particular to this grouping, and that's why I would rather want to spend a bit more time on what is particular to grouping. I think that is needed in the background. I think we should just be getting on with it. All other sectors are doing it anyway. To my mind, I just wanted to raise, what are the other alternatives, which I hope we would spend a little time on.

And there was a question Jerry Carvodia [misspelled?] asked and nobody really answered, which I think strikes at the heart of the question of global health. He asked, if I heard him correctly, what do people do as their day job if they've got the title global health in their job description and how does that differ from other aspects of public health? I have some very strong views, since it's in my job description, and I would love to actually have that discussion answering two very specific questions. One is what actually do we do? In other words, what's the scope of our work in a job description with global health in it? What is out of scope? Where do you work with a job description of global health? I think we may have some interesting and surprising discussions, which I hope would clarify the field a lot more than it is.

ALASTAIR AGER: Miguel?

MIGUEL GONZALEZ-BLOCK: The need for knowledge networks is clear. However, I would have welcomed to see a little bit more on the purpose and incentives for collaboration in such networks, particularly in terms of strengthening capacities among the global community. The importance was relating to existing knowledge networks that have been mentioned, but in other words, there's a need to map diverse knowledge networks as they exist and to identify the challenges that they already have.

One of them is the knowledge network we're building for implementation research for access to innovations for infectious diseases with the leadership of TDR from WHO and other partners, and mapping that network has led us to identify important gaps in terms of capacity by the south. Publications are particularly low and 75-percent of publications are by the north. Only half of them are in collaboration at all, so how can you imagine implementation research leading to publications by one author? That makes little sense, but that is the way things are so we need to move further ahead in those fields. Thank you very much.

ALASTAIR AGER: Go ahead sir.

ROHIT RAMASWAMY: Yeah. I wanted to talk a little bit more about— I think clearly there is no doubt that having a knowledge network is valuable and important. I think the last

bullet that you put pointed on sustainability is the one that concerns me the most because there's no point in having a knowledge network just for the sake of having one, because then it becomes wasteful.

So, ultimately if the idea is to be able to use these networks to drive innovation or to be able to extend the ideas that have come out as a result of the gathering here, the knowledge networks have to be able to do some work. A lot of the researchers 20 years ago, two engineering professors did some research on what made knowledge networks successful at innovation, a lot of the work they did was around the automobile industry and they found that there were two processes that needed to work together in order for successful knowledge networks. And they get to be external process where kind of new external data and knowledge was created and kind of pumped into the organizations, but they needed to be supported by the internal processes where the knowledge was actually taken in by the organizations, used and reused and reshaped in ways that actually made sense to the organization and then pumped back out for the system.

So, this balance between external and internal processes was a critical step in making sure that knowledge networks worked and they produced information that was useful. The second thing that they found was that in order to make

these external and internal processes work required a lot of effort.

So, in terms of auto eye [misspelled?], to be able to actually kind of generate some return investment on the amount of effort we put in, we have to make sure that we're established in the processes to do that, and as someone else said, that that is an incentive to make this happen. In the absence of that, it just becomes a— nothing more than a vehicle for a sharing pass of knowledge which is really a waste of everyone's time.

ALASTAIR AGER: Thank you. Florence.

FLORENCE BAINGANA: Thank you very much. The first thing, just two quick comments, the first one is I think knowledge networks are very important for moving forward and moving whatever's going on here forward and they don't even have to be very expensive, the knowledge network that is set up. Because of information and technology developments, we could even do the networking virtually.

So, it doesn't have to be that we can't physically, together, every hour, every three months, and I think this will also ensure our equity in the participation between the north and the south. In relation to the question that Derek asked, I don't think we have to create a new kata of a global public health specialist. I don't think so. I think when we train

people— I started a mental health program within the global health program of George Washington University and the people that we were training, we didn't train them to become global health specialists, but I think we trained people so that they can think globally but act locally for wherever they may be. They may go back to become— to going their ministries of health and work there, but they'll develop programs that can interface very easily with and they have a clear understanding of what is going on globally so they can work with WHO or any other global organization. They could work with international NGO's or even with local NGO's, so it's not a kata that is specifically trained to take on a new role and then we create that role, but it's a kata that can work in any kind of situation but work there much more efficiently.

ALASTAIR AGER: Thank you, Florence. Kenneth.

KENNETH CARMARGO, JR.: I think one of the things that we might look into is what the opposition is already doing in a sense. Someone mentioned, for instance, the menace, the threat to vaccines, the vaccination programs that the Anti-Vax movement has been represented and what they are doing. They are networking through using the internet. They are creating repositories of this information on the internet. So, basically I think there are two types of action that we could use. One is the internet working with regards to agency, to

advocacy. There are a number of organizations like AVAS and Amnesty International, etc. that have been recruiting support from all over the world to southern causes creating manifests and people sign up, etc.

The other is to try to create data and knowledge repositories. I think in this regard, I think it goes partly to what Miguel was saying. We have to move a lot of knowledge into public access away from the restricted journals that we now have in order that everyone has access to data papers, etc., and also to break with the hold for instance, DHS services have. The raw data should be available as well and people doing analysis should be communicating with each other. I think this— the two lines of work that we might think of— there was something else that I just forgot.

If I recall it, I'll call it— the important thing is what Richard said. Most of the infrastructures already— oh yea, I just recalled it. I would just like to register for the record, historical record, that there is a professor here in the U.S. of the Pittsburg University called Ronald LaPorte who, years ago, created something called The Global Super Course in Epidemiology. They already have a massive amount of data and information and I think he should be one of the persons that should be contacted in order to give some guidance of this process. Thank you.

ALASTAIR AGER: Okay. Let me clarify. There are two things that are not negotiable and one thing that is infinitely negotiable. One thing that's not negotiable is that we are shortly to go to lunch and we need to eat. A second thing that's not negotiable is we want everyone to go away with a sense of potential purposeful action that we are not going to allow there to be a broad and interesting discussion but no sense of traction on these issues.

The exact structures we use is completely open. We have this wonderful facility of having 10 or 11 tables of having yourselves then an opportunity to group yourselves immediately after lunch, in the way that makes sense for you to drive it forward. We are not going to be driving this forward. We don't need to [inaudible].

It's not for us to create. It's for a group that feels that there is something worthwhile doing within a knowledge network, but that group can come together. Our initial thinking was that it was like that around these four key things, that maybe a group of you that around changing health and prevention needs, around science and technology, around globalization and health governance, around health systems.

There may be groups in each of those themes that would want to meet together to discuss whether it's an all lease network or by what means take things forward, but there will be

other things that are emerging, and in the last two or three minutes I really want to just pick up on other peoples suggestions of how we use this time between two and three when we get together in groups to make some plans and to make some action steps. The ways that we can use this as a marketplace to basically say "come and sit by Marion if you want to talk about this." So, can I use that as a cue to bring you in Marion?

MARIAN JACOBS: Just to say about knowledge networks, yesterday when I spoke, I listed about similar [inaudible] really exist. So, I wanted to support Miguel and say that we need to map what's already going on before we start something new and perhaps that mapping should have a subset of topics. The second point is that [inaudible] report is now running a global course on global citizenship or something like that, so it is connected to a number of institutions.

My third point is that there is a second part to Jerry's question. He asked about job descriptions, but he also asked is it necessary not have new departments of global health and of course virtually every U.S. institution that I can see, even in the U.K. now has a global health institute, a global health initiative, a global health something.

So, I also now have a global health institute at The University of Cape town and the question is, the reason for

that, is when I looked at the curricular and the objectives of all the institutes in North America, I saw that they are doing exactly what our daily work is anyway.

So, I'm quite keen for there to be some discretion on global health institutes at universities so that we can perhaps at some point, if there's a clearinghouse of curricular, there's a clearinghouse of publications that might be more useful to us. The last is there is an open access journal and Helen knows all about it.

So, there is an opportunity to publish quite quickly in that open access journal and I hope that some of the deliberations of this meeting will be turned into publications that can go into their journal because I think that that's quite a useful way of getting the debates and the discourse out into the global public domain.

ALASTAIR AGER: Thank you. If you go to [inaudible] behind you, then I'll come to Gita.

SONIA CORREA: Thank you. While I think the creation of a knowledge network as an outcome of this meeting would be extremely laudable and there seems to be a consensus that we certainly should explore that seriously, but I think there's a lot of critical thinking that needs to be done before that and following up on Miguel and Marion's comment, I think you need to explore where your comparative advantage lies and where this

particular niche is. I think the deliberations over the course of the two days have given us some very useful clues because we know that there are some important transitions currently underway and the trick would be in focusing the objective and the deliverables of the network on those specific areas.

I mean, there seems to be a sense of agreement that we need to move towards a coordinated global response towards non-communicable diseases that health and all policies is an emerging team, that health systems is an emerging area of focus, that there are certain contiguous issues that tradition multi-laical institutions do not tend to focus attention to in an independent manner, for instance trade and the issue of migration that we haven't talked about.

All that there are some fissures and fracture lines within conventional multi-laicrilism [misspelled?], particularly with reference to its inability to engage the private sector and its lack of accountabilities to people, a visibly government, which is not how it ought to be. I think a network, which brings value to these underserved areas would bring tremendous value.

Secondly, Alastair, on your point about your desire for a group of experts to lead and drive this network is certainly laudable indeed, but then it has to have a house and home and it has to need— somebody has to host it and clearly, if an

academic institution takes on that responsibility, you'll have to examine where you're comparative advantage lies and both have done the structuring it, as well as driving it, so we fully support it.

ALASTAIR AGER: Just to clarify, I completely view what you're saying, but it's the we's. So, what do we want to do? I'm very much hearing that. Gita, and then I'll take a couple final comments and then we'll draw to a close.

GITA SEN: Can you hear me?

ALASTAIR AGER: Can we have the mike here please?

GITA SEN: Just very quickly— can you hear me in the back? Just very quickly on, from the experience of the WHO Commissions Knowledge Networks, I think one of the things that was very important to keep them on track and keep them going was, it wasn't just about the laudable outcome of improving knowledge and put on social determinacy about, it's actually very concrete outputs and those were extremely important in ensuring discipline in the functioning of the networks and I think that that's something to pay a lot of attention to. Given the fact that this is a group of people that is generally, you know, sitting around with nothing to do.

So, you know, if you have emails or websites or whatever, internet of a knowledge network, that the likelihood if there is not a discipline of an output that you would

actually engage in a serious way is somewhat questionable. So I think that's one aspect of it to really think about. Is there something? The second thing that was very important for the WHO knowledge networks was that there was a collective agreement about the importance of social determinacy of health, and so that functioned in a sense as an ideological glue to the, even though there were lots of disagreements within the networks across networks, and so on about how, what specifically, and so on, but there was a collective glue.

I suspect there is some such thing here around, and I've heard sort of value statements being repeated a number of times which nobody seems to have disagreed with, but I think that that's something as well to think about. Finally, just to agree with Sonia's point, that it needs a home. It's difficult to create a kind of we at this point. Even if it's a temporary starting home from which you then, you know, send it out into outer space.

ALASTAIR AGER: Thank you very much, Gita. Well, I think we do need to go to lunch now, but just to clarify one process thing, we will, it sounds like, establish four tables for people interested in taking forward those four themes. We may have a fifth table looking around global health institutes and centers. You have the next 45 minutes to lobby us about what the other tables might be, if there are particular foci so

that when we come back we can have a marketplace of saying. If you're interested in taking actions forward in this area, this is where you go to and that could include constituencies, it could be the people you met with yesterday you want to caucus with and think forward. It's for yourself to think of options and then we'll lay them out before you to choose at 2:00. So, enjoy your lunch. Sorry Howard.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.