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Collaborative design, local leadership, local impact: some experience and reflections from DFID/ESRC- and GCRF-funded health research

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Five topics to generate discussion, with examples from health projects

1. Resilience: robust systems not individual behaviour change?
2. Which local actors? Geography meets hierarchy.
3. Local priorities: sharing research design and shifting research leadership.
4. Risk management: not the same as central control.
5. Generating local impact: trusting locals, partially letting go.

1.Resilience: system resilience not individual behaviour change?

Commentary from health, where concept is widely used:

- Global health researchers, 2016: suggest the dominant focus on resilience tends to bypass issues of power and structure to emphasise “self-reliance and behavioural change” by the weak.
- “Adaptability without robustness is not resilience” (BMJ Global Health 2018 editorial) : don’t confuse a resilient system with individuals’ ability to adapt?

Lesson from the health debates?

- Focus on robust structures, not coping techniques?
- Ensure resilience isn’t the “final burden imposed by the powerful on the powerless”?

2. Which local actors? Geography meets hierarchy

If equity is a central research concern then “local” is both **geographical** and **hierarchical**: people working within local systems of power and policy, and people at the lower end of power hierarchies. Possible lessons from health:

- Local researchers and research organisations: go for mutual learning and local research leadership: avoid situations where HIC researchers treat well qualified LMIC colleagues as effectively research assistants, with limited funding to match.
- Spend *time* to ask about and to generate understanding of local priorities; look for local research colleagues with shared ethics and commitments, and stick with them over time.
- Try not to by-pass LMIC governments, national and local: try to find colleagues to work with within governments.
- Working with local business: identify areas where local business interests can serve local need; investigate local/global differences in business objectives and outcomes, and look for scope to promote local developmental benefit; don’t focus on international CSR.
- Be open minded about the range of local NGOs to work with: e.g. what about trades unions?
- Look for scope for e.g. lower level professionals to undertake research leadership (e.g. nurses).

3. Local priorities: sharing design and shifting leadership

1. Real scope to shift research leadership geographically, very hard to shift it hierarchically:

Many examples of funded projects where the core ideas have been generated by African colleagues.

Harder to fund research led by lower level professionals e.g. nurse-led research including action-research.

- Keep trying to widen research hierarchies? Listen widely, to many different local actors; develop the scope for research leadership by unfamiliar actors.

2. Real scope for compromise and finding overlapping priorities:

Quote from a BMZ report based on our work 2017: “Global health security frameworks focus on technologies for emergencies that threaten the wider world. African experts shift the focus onto breaking supply constraints for recurrent lethal emergencies by building local supply capacities and organisational expertise. Both contributions are needed to build medium-term health security.”

- Faced with conflicting priorities? Look for common ground and global-local overlap; be willing to compromise; keep trying; identify call framing that blocks local priorities.

4. Risk management: not the same as central control?

Good to see risk and risk management as an important focus in this call.

Lessons from health research?

- Envisage, track and address unintended consequences: take care that interventions do not shift risk-bearing *towards* the most vulnerable.
- Use a wide definition of types of risk and who bears it.

Lessons from health:

- Central control and single channel management may reduce one set of risks but worsen others
- Diversification of sources of supply in this case can lessen risks across the system
- Reducing risk at the bottom is hard, and may require loss of central control.

5. Generating local impact: from dissemination to involvement in policy processes

Health research with high impact: lessons:

- Trust local researchers to design and lead – which means changing the concept and activity of a PI somewhat in the process;
- Work with locals embedded in local policy processes – which means recognising that as PI you are therefore not in charge of local impact.
- Rethink the PI impact role: “orchestrating not framing”?

Examples:

- Feed the impact process: e.g. finding the “killer diagram”, attracting international attention to local results.
- Ensure funding for impact from day 1: initial workshops with policy makers; building in feedback workshops that act *as* research by influencing research follow-on; effectively recruiting key policy actors into ongoing research design.
- Be flexible: so the impact envisaged did not come through, but a different aspect has grabbed attention? Work with that ..
- Create a division of labour: as PI, work on international presence of the research, and let local research leaders generate local impact and get the credit.