Oxford Policy Management

Learning across health systems: Chairperson's summary of the Prince Mahidol Award Conference Side Meeting, 29th January 2018.

Context and purpose of this note

The Bill & Melinda Gates Foundation (BMGF) wishes to better understand how low and middle-income countries (LMICs) improve their country's health systems and health outcomes by learning from other countries' experience.[1] BMGF also wishes to identify possible investment options that the Foundation, governments, and other development partners could possibly invest in to facilitate better learning between countries, particularly in Africa. BMGF commissioned OPM to analyse the circumstances under which LMICs learn – or don't learn – from each other and to generate some options for possible investments that would improve the situation.

The Prince Mahidol Award Conference (PMAC) side meeting provided an opportunity for OPM to explain the research it had conducted, and to seek comments from participants on possible investment options for facilitating learning between countries, especially in Africa.

The PMAC side meeting was open to any PMAC conference participant wishing to attend. Fifty-four individuals participated from a wide range of countries, including a mix of Asian, African, European, and American attendees from government, universities, research institutes, the health sector, and civil society.

The following note summarises the main points of the discussion at the side meeting. The note begins with the initial presentations. The summary of those presentations is brief because the PowerPoint presentations used at the meeting are available here. The note also briefly summarises the observations from the panel of experts. The bulk of this note then summarises some of the key comments, and questions, posed by participants during the open discussion.

This note is provided by the Chairperson of the side meeting, Alex Jones of OPM, on his own responsibility and for the background use of those participating in the side meeting and others who were not able to attend. This note is not intended to be a fully comprehensive or formal record of the side meeting.

Developments to date and possible options

Developments to date

Alex Jones explained the process that OPM had used to date to better understand how countries learned – or didn't learn – from each other and how that had informed the development of potential investment options. In short, OPM has so far:

- Undertaken **landscaping reviews** including literature surveys, and an illustrative 'mapping' of existing institutions that have learning between countries in the health sector as part of their mandate.
- Conducted **two Expert Group meetings**, in London and Kigali, to analyse the constraints and opportunities for learning from other countries. These two meetings involved over 50 experts from a wide and representative range of experiences and interests including government, universities, and multilateral organisations.

[1] More specifically, the BMGF wishes to better understand: *What* can countries learn from one another's experiences? *How* do countries learn from one another's experiences? *Why* do policy-makers sometimes want *or not want* to learn from one another's experience?

- Conducted **eight country studies** and field interviews to better understand the experiences of countries in different regions[2] that had demonstrably strengthened their health systems in some way.
- Conducted interviews with **eight key informants**[3] that had a mandate for supporting learning from other countries.
- Used each of the above processes to further develop and refine possible investment options for those wishing to further support learning between countries, especially in Africa. Three possible options have emerged from this process, which are explored below.

Possible options

One option, presented by Ian Anderson, was to **strengthen the existing African Health Observatory (AHO), particularly by broadening its partnership linkages with others**. In essence, the argument for investing in the AHO is that:

- It is an existing pan-African web-based platform, housed within the WHOAFRO, that has a clear and direct mandate for facilitating learning from other countries.[4]
- It already has direct access to official health data and statistics of 47 African countries, and links to their ministries of health, because AHO is housed within WHOAFRO.
- It currently has a low profile and appears to be performing below its potential. That is possibly because it is under-resourced, although that then raises the question *why* has it remained under-resourced: is there actually a lack of demand and commitment from governments in Africa to make the AHO a central part of learning from each other? Initial analysis also suggests the AHO is performing below its potential because it appears to lack the strong and durable institutional partnership links with governments, universities, research institutions, and other stakeholders that many believe is a hallmark and explanation of the relative impact and effectiveness of the European Health Observatory.[5]

A second option, presented by Professor Barbara McPake, was to **approach the issue from the individual country perspective by promoting national Centres of Excellence.** The argument for this option is as follows:

- National ownership and control over the process of generating and using evidence, including from other countries, is an essential part of the learning process. This will inevitably vary between countries. Having respected and credible national institutions that can broker and explain such learnings in ways that suit local needs is an essential part of contextualising and adapting evidence and lessons to local circumstances.
- To be both credible *and* effective, such national institutions need to have a degree of independence and disciplinary rigour (hence the likelihood they will involve national

[2] The eight country case studies involved, in alphabetical order: Bangladesh, Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Rwanda, and Solomon Islands
[3] The key informant organisations are, in alphabetical order: African Health Observatory (WHOAFRO); Asia Pacific Observatory on Health Policies and Systems; Collaborative African Budget Reform Initiative;
European Observatory on Health Systems and Policies; International Decision Support Initiative; Joint Learning Initiative; Performance Based Financing Community of Practice and The Collectivity; Swiss Tropical Health Institute and REACH.
[4] The AHO website states that the AHO is a web-based platform that has the following four functions, all of which are directly relevant and needed to facilitate learning between countries:
a) Storage and sharing of data and statistics for elaboration and download if needed;
b) Production and sharing of evidence through the analysis and synthesis of information;
c) Sustaining networks and communities, for better translation of evidence; and
d) Supporting countries establish national or sub-national health observatories.
[5] See www.euro.who.int/en/about-us/partners/observatory

universities/research institutions, partnering with overseas institutions where necessary). But they will also have strong links to government decision makers to ensure their work is relevant and useful.

- Activities from the Centres of Excellence could include country health system analysis reports similar to other Observatory HiTs[6] and/or policy briefs and facilitation of study tours.

The presenters made clear that **other options are available, particularly including a hybrid model** that combines the best features of the AHO with the best features of a network of national Centres of Excellence. The presenters also made clear that the whatever approach was eventually adopted, it would first need to be tested with and designed in more detail with the active engagement of national governments in Africa and other key stakeholders. Once a scoping study confirmed the interest and commitment of governments and other stakeholders then it would be prudent to invest in a stepped, sequential manner. More specifically, while 'the vision' may be bold, it makes sense to sequence various investment packages to make sure the basic building blocks are in place and working before moving to more ambitious levels.

Panellists' responses to the options

Three senior and expert panellists from Africa provided their observations on the presentations.

Dr Clifford Kamara, former Health Coordinator of the President's Post-Ebola Recovery Programme in Sierra Leone, observed that:

- Most countries are not in a vacuum as far as learning across countries for policy formulation is concerned. It will therefore be key to determine on a country-by-country basis where best to locate the Centres of Excellence, and when and how the process should fit into the existing planning and policy formulation cycle in each country.

Instead of first strengthening the AHO and then focusing on establishing the Centres of Excellence, it is probably more prudent to conduct these activities simultaneously, step by step. Clearly these two proposed strategies are complementary, and there does not appear to be any comparative advantage in implementing one before the other.

Dr Juma Kariburyo, former Minister of Health, Burundi, drawing particularly on his recent work in the Mano River Region, observed that:

- There is a need to: (i) strengthen national strategic information systems (to generate and share data and evidence on a quarterly basis); (ii) to plan for human resource training and coaching (including community health workers); (iii) to set up national observatories and sub-regional observatories (with a need for regular audits of a defined performance framework and expected results, including the: chain of responsibility; chain of accountability; chain of evidence (data collection and evidence generation); need to produce, assess, and share best practices and encourage countries member to learn from each other); (iv) plan for biannual meetings of technicians to discuss progress and obstacles on one hand, and learn from each other on the other hand (including the organisation of study tours); and (v) plan for a meeting of decision makers and parliamentarians from the four member states to share the main figures and

[6] HiTs stands for Health Systems in Transition. Further details about the purpose and nature of HiTs are available at www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits/about-the-hits-series

evidence and ensure their decisions are based on concrete facts and better guide use of the few funds available.

- The health sector does not stand alone. We need to involve other development sectors and the community on one hand and to build strong inter-sectoral partnerships and synergies on the other.

Dr Eusebio Chaquisse, current public health specialist, Ministry of Health, Mozambique, observed that:

- Learning for action implies training human resources at different levels and from different sectors and communities. Implementing the principles of Primary Health Systems and the Sustainable Development Goals could be opportunities to encourage countries to learn from each other. The Centres of Excellence can act as a platform for gathering and delivering experience (successes and failures) and good practices from countries or different regions within the countries. The Centres of Excellence and a reinvigorated AHO could be seen as two institutions that complement each other and work together.
- There is a need to strengthen the process of data collection, in most African countries, to make health system information reliable enough to be used for decision-making processes. This could also allow countries to share and measure the progress of their activities as results of the learnings from other countries. Health system information should also encourage multi-sectoral, intra-sectoral, and community participation. Reliable data may create demand for good health services and encourage governments to use the Centre of Excellences to share the information. There are some multilateral organisations that should be considered in the process of identifying the organisation that could host or coordinate the Centres of Excellence, such as the WHO or other organisation or sector recognised by the country government.

Responses from the floor

The following summarises some of the key themes arising from the open discussion that involved all participants. As Chair of the meeting, I have grouped the numerous comments made under a series of thematic headings. The themes below are not listed in any particular order of importance.

- **Implementation.** Focusing on the steps from evidence to policy making is important, but is not enough by itself. That is because in many countries the key gap and point of breakdown is the gap between policy and actual implementation. It is therefore important to understand the institutional incentives and circumstances that drive an effective use of evidence and learning from other countries to not only inform policy but also actual implementation. We should not lose sight of the important role that NGOs, faith-based organisations, and civil society can play in implementation, especially in LMICs of sub-Saharan Africa.
- **Resources.** Generating and disseminating evidence and learning from other countries is important, but will not get traction if there are not resources – money but also human resources etc. – to actually implement change. Quality care costs money. Knowing what to do but lacking the money and other resources to do it does not lead to action. On the other hand, this project has always been premised on the insight that some countries, especially in Africa, do get more and better health outcomes for the same amount of money than neighbouring countries spending much more. Learning from countries how to allocate scarce resources to more efficient activities is therefore part of the aim of learning from other countries.
- **The importance of regional *and* national organisations working together.** Participants generally agreed with the point made by the OPM presenters that the AHO option and the national Centres of Excellence option were not alternatives that excluded each other. They

were not 'either/or' but rather involved working together. That is because an observatory will not function well without national-level presence, and national-level bodies need a regional framework within which to share evidence in a way that is comparable and allows accurate benchmarking between countries. Perhaps there was a need for a 'hub and spoke' model with a rejuvenated AHO (involving, among other things, stronger links to other institutions such as governments and universities). A rejuvenated AHO could then provide a central coordinating function linked to national Centres of Excellence which, themselves, could generate country data and insights, policy briefs, and lessons learned that could be fed back and up to the AHO.

- **The importance of a multi-sectoral approach.** Health outcomes are influenced by many factors outside of the formal health sector. These include factors such as water and sanitation, food security, education (especially girls' education), poverty, climate change, etc. It is therefore important to learn lessons from other countries about how those factors influence health. A regional observatory on climate change had recently been established in Africa:[7] it would be important for any regional or national health observatory to link up with that climate change observatory and similar institutions in other sectors that affect health outcomes.
- **Demand versus supply of evidence and learning from other countries.** There appears to be a reasonable level of 'supply' of evidence and learning in existence already, including that coming from national, bilateral, and multilateral institutions. But such evidence and learning from other countries may not be used. It is therefore important to focus on stimulating *demand* for evidence and learning among decision makers. One participant said that it felt like pure luck whether evidence fell on listening ears or not. Another participant noted their organisation had had success in matching demand with supply by actively engaging politicians in the design of applied research projects right at the start of the activity. The aim was to ensure that the evidence being generated would address practical and specific problems decision makers were wrestling with. There was a process of continuous liaison with politicians and decision makers throughout the applied research so that the exercise continued to be relevant to those using the insights generated, while still maintaining the independence and rigour of the research itself. Other participants noted that to stimulate demand it was important to note that users of evidence and learning from other countries may prefer modes of engagement other than reading long reports. For example, they may prefer study tours, short policy briefs, training, etc.
- **What might be useful and 'needed' may not actually be 'demanded'.** Most agree – at least in principle – with the proposition that all countries need to have good evidence and can potentially benefit from learning from each other. However, it also has to be recognised that governments and other stakeholders at a national level may believe that, *in practice*, they have little to learn from other countries because their country circumstances are 'different'. Perhaps the lack of active demand for learning from other countries helps to explain why there appears to be little desire on the part of governments to date to make the AHO more active and high profile, or countries establishing their own Centres of Excellence. One barrier to demand from governments may be that Centres of Excellence are about bringing change. Bringing change is a complicated political task. Even as a Minister it can get you removed from office. Having a more purposeful and strategic approach would encourage the generating and disseminating of evidence and learning in ways, and at times, that is useful to decision makers.
- **A focus on Africa should not exclude global lesson-learning**. The scope for learning is global. While context and national/regional characteristics helped to make evidence and learning relevant, there were nevertheless certain universal challenges (e.g. how to ensure a health workforce is distributed fairly and sustainably to remote and rural areas) and approaches that all countries could learn from. The challenge and skill then relates to contextualisation. But this is not an absolute barrier. There are organisations that seek to share learning at a global level, including several UN and multilateral agencies (WHO, UNICEF, UNFPA, World Bank,

[7] www.idrc.ca/en/article/regional-observatory-producers-climate-change-adaptation-thies-senegal

etc.). There are other agencies as well. For example, Health Systems Global state that their core activities span three broad areas of work that are relevant to international learning: (i) foster the creation of new knowledge; (ii) support knowledge translation focusing on bridging knowledge creation with practical application; and (iii) foster research on the application of new knowledge in real-world settings.

Next steps

Following feedback from this meeting, the recommendations will be further refined and re-presented to a group consisting of WHO representatives and funding agencies towards the end of February. The final recommendations will be submitted to the BMGF in early March. They will then consider funding options and how to proceed.

Acknowledgements and thanks

I would like to take this opportunity to thank the presenters, the three expert panellists, and all the participants at the PMAC side meeting on learning for action for their constructive contributions. Your feedback was exceptionally constructive and useful. I also wish to thank the Royal Thai Government and the PMAC organisers for the excellent arrangements that enabled us to give our presentations.

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