Oxford Policy Management

Chairperson's Summary

Learning For Action Across Health Systems

Second Expert Convention, Kigali, Rwanda, 16–17 November 2017

1 Background to the meeting and purpose of this summary

The Bill & Melinda Gates Foundation (BMGF) wishes to better understand how low -income countries (LICs), particularly in sub-Saharan Africa, learn from the experiences of other countries, and put those lessons into practice as they reform their health systems.[1] Oxford Policy Management (OPM), commissioned by BMGF to support that work, convened a second meeting[2] of international experts to discuss the issue in Kigali, Rwanda on 16–17 November 2017. Twenty-four experts, selected for their knowledge of policy and learning processes, both in their own countries and internationally, from 20 Anglophone, Francophone, and Lusophone countries in Africa[3] participated. The participants list can be found in Annex A. Representatives of BMGF participated as observers. Discussion was held under the Chatham House Rule.[4] This summary has been prepared by the chairperson of the meeting[5] as a reminder of some of the key points that emerged from the discussion. It is not an official record of the meeting or intended to be a consensus document.

[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?
[2] The first Expert Convention was held in London on 9 May 2017.
[3] In alphabetical order: Benin; Burundi; Chad; Comoros; Congo Democratic Republic; Ghana; Guinea Bissau; Malawi; Mali; Mozambique; Niger; Nigeria; Rwanda; Senegal; Sierra Leone; Somalia; Tanzania; The Gambia; Togo; Zambia
[4] When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.
[5] Alex Jones, Health Economist, Oxford Policy Management.

2 Developments to date in understanding how countries learn from each other

The meeting began with OPM explaining the research undertaken so far. OPM explained it had undertaken research to better understand the existing 'landscape' of what, how, and why countries learn from each other and how they turn those lessons into action. For example, a quick OPM review identified 231 examples of published articles that presented comparative health system analysis, involving information from two or more countries. That review found, among other things, that there was an expanding body of comparative health systems literature, that a significant share of this research addressed LMICs, and that certain topics were more commonly studied than others, with health financing receiving the most attention among the health system functions. In a second piece of research, OPM identified 166 illustrative examples of different organisations or 'platforms' that had sharing of learning in the health sector as an important part of their work. These platforms included universities, UN and multilateral organisations, think tanks, conferences, etc. OPM noted that while there are many such platforms few, if any, had been independently evaluated in terms of their effectiveness in facilitating learning between countries. In a third piece of research, OPM looked at the international health policy transfer process, i.e. what is known about the *process* of learning from another country's experiences and designing reform accordingly. OPM concluded that cross-country learning and policy transfer could be thought of as occurring in six broad stages,[6] starting with an early vision or concept and progressing through to evaluation.

Discussion with experts at the First Expert Convention in London further advanced understanding about what, why, and how countries learn from each other and how they convert these learnings into action. Some key themes to emerge from this meeting, held in London on 9 May 2017, are summarised in Box 1 below.

[6] The six broad stages of learning and policy transfer can be thought of as involving conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation.

Box 1: Some key themes to emerge from the First Expert Convention in London

Learning is more than just sharing information and evidence. Nor does it involve simply copying from others. Rather, it ultimately involves digesting and adapting lessons to the country perspective and then internalising / institutionalising that learning. **The political economy of learning is always and everywhere important.** What evidence, whose evidence, how that evidence is presented, and the timing of that evidence in the political and budget cycle are all important determinants of how effective knowledge transfer, learning, and putting lessons into practice might be. The **audience** for evidence matters. The evidence that a Ministry of Finance finds relevant and convincing to health system reform may well be quite different to that used by the Ministry of Health. **Incentives** – at the institutional and personal level – matter in terms of the demand for learning from other countries. **There are many routes to learning.** Commonly mentioned examples included study tours, technical assistance, and informal networks. **Failure to learn, and learning from failure**, are important. Some countries appear not to take account of previous health system reform experiences, even from clear evidence and lessons within their own borders. All countries can benefit from 'learning from failure', yet there are usually strong disincentives to document and disseminate lessons from failures. Some countries 'learn the wrong lessons' from the experience of other countries. There was an appetite for learning from others about the successes – and failures – of **implementing** reforms in the health sector. A particularly important finding from the London meeting was that **learning from other countries in the health sector was a crowded – but also fragmented – market place**. In other words, there was a great deal of information and insight available, but many countries found it hard to navigate and access their way through to find the credible 'trusted' learning they needed.

In Kigali, OPM also provided feedback about specific stakeholder interviews focusing on existing learning platforms and eight country case studies to better understand the role learning from other countries plays in reforms. OPM interviewed eight key informants[7] from organisations that supported learning from other countries. This revealed that there is a wide range of existing platforms, a wide range of hosts for the platforms (universities, UN, etc.), a wide range of funding models, and a wide range of activities supported. Success factors included having a country-led agenda, having the right people involved, having the buy-in and support of senior leaders, using peer learning, and having trusting relationships. Challenges included measuring/demonstrating effectiveness, funding/resources issues, moving beyond products to policy dialogue, and managing expectations about the time needed for reform – which sometimes requires a generation. OPM also undertook eight in-country case studies,[8] and some of the key findings of these are summarised in Box 2 below.

[7] The key informant organisations are, in alphabetical order: African Health Observatory (WHO/AFRO); 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.

[8] The eight countries are, in alphabetical order: Bangladesh, Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Solomon Islands, and Rwanda. These countries were selected based on criteria including that they had successfully implemented – and sustained – substantive sector-wide reforms in the health sector.

Box 2: Some key findings arising from the country case studies

Countries can spur substantial reform despite – or perhaps because of – **political and economic shocks and conflict**, and in doing so provide lessons for others. In general, countries were more interested and open to learning lessons from others at the early 'vision' or conceptualisation stage than they were in later implementation stages. Successfully reforming countries had a culture of **continuous learning**, including through good quality, real-time monitoring (and sometimes evaluation) of pilots and programmes as they are scaled up. There are many mechanisms and entry points for learning: at the international level (including South–South study tours, and technical advice from WHO, etc.); at the regional level (including professional networks); and at the domestic level. Take-up of evidence is a complex issue: evidence is more likely to be acted on by decision makers when it is: politically relevant, accessible, and locally applicable; presented at the right time in the budget/policy cycle; and presented in an appropriate format (e.g. sometimes oral presentation is preferred to written). Some of the facilitating factors behind demand for evidence included performance orientation within the government and public administration, and functioning internal learning processes (which also facilitate intelligent filtering of external lessons). There are also several barriers to learning from other countries, including incentive structures, donor pressure, overall capacity to use learnings, and undermining by vested interests.

3 Main developments at the Second Expert Convention in Rwanda

Building on those findings, the goal of the Kigali meeting was to identify recommendations and options to support cross-country learning for action that could be presented to low-income countries in Africa, the BMGF, and other development partners early in 2018. The overall process of developing options, which involves a logical progression from assessing the broader landscape to focusing at the Kigali meeting on specific recommendations, is described diagrammatically in Annex A.

Experts at the Kigali meeting made several observations at the overarching strategic level. Many experts highlighted the opportunities – but also the constraints – of using the **internet** to learn from other countries. Many noted that internet coverage and penetration was poor and/or slow. This was particularly a problem in rural and remote areas that, under decentralised health systems, represent the front line of health service providers. Even where internet coverage was good, there remained the challenge of identifying reputable and reliable information. Many experts referred to the challenge of **language and communications.** Francophone countries did not have easy access to the lessons of Anglophone countries, but neither did Anglophone countries have easy access to the lessons from Francophone – or Lusophone – countries. There was also often a heavy reliance on long written documents to communicate lessons whereas videos and other media were likely to be more accessible and cost-effective, but underutilised, means of sharing lessons. Several experts referred to the role that **culture** played in lesson-learning. Experts suggested this was a very broad area, but included themes such as leadership and governance, protective ownership of information, the need to better package lessons so that their relevance becomes clearer and more useful to policy makers, and the existence among some countries of an assumption that 'our setting is unique and it's not clear whether lessons from other countries are relevant'. Some experts noted that geographic proximity 'isn't the only type of "proximity" that facilitates learning and relationship-building; for instance, it may include cultural, structural, and linguistic proximity'. Face-to-face learning was cited by many experts as valuable, but if such lessons are not institutionalised then the lessons are likely to be lost and not sustained. Many experts also highlighted the importance of **human resources and capacity building.** Again, several themes were explored: the different nature of short-term versus longer-term training; the possibility of using expatriates and returning diaspora to share lessons; the need for clarity of purpose in training and capacity building; and the importance of performance management and 'managing for results'. An overarching point was the importance of learning for a purpose, and linking that purpose to sector implementation plans. A ministry should plan what it wants to learn, and that should relate to what it wants to achieve.

Experts then worked through a process of identifying specific options and recommendations for improving learning for action between countries, starting with some broader principles. The first step was for experts to consider 10 broad principles[9]

[9] The 10 broad principles that had implications for identifying specific options and recommendations are as follows: 1) Learning is more than just sharing information and evidence. 2) Political economy factors will determine the extent to which countries have an appetite to learn from each other or not. 3) There is no single solution, meaning context-specificity is key. 4) Different actors require different approaches. 5) Trusting relationships and being perceived as an 'honest broker' are key for evidence suppliers. 6) The market for learning from other countries is crowded and of unproven effectiveness in terms of existing international mechanisms. 7) There are regional/cultural/language factors that must be taken into account (e.g. sometimes geographic proximity helps). 8) We can learn from failures, but they are less often shared. 9) Capacity to learn from outside

identified in the work to date by OPM that would *appear* to have implications for developing more specific recommendations. Experts discussed and tested these 10 principles at some length in break-out groups. They elaborated and augmented these principles based on their own extensive experience. With these edits, it was agreed the 10 principles were a good starting point and foundation for then identifying recommendations.

Having identified broader principles, experts were then invited to consider and identify specific activities that they considered presented the best opportunity for learning for action from other countries and best opportunities for this learning to translate into actions. A large number of specific activities were identified under four broad headings. One heading was 'making more effective use of existing evidence'. Examples included exchange programmes that focused on operational tools and implementation experiences. A second broad group of activities consisted of generating new evidence. Activities here included comparative health system research, independent evaluation of existing learning platforms, and co-production of technical materials. A third broad group of activities involved 'people learning'. Activities here included participation in international and regional conferences, study tours, technical assistance, and formal/informal capacity building. The fourth broad heading of activities was improving the operating environment for learning. Activities here included improving access to the internet, increasing the availability of learning in languages other than English, and encouraging more real-time evaluation and lesson-learning from pilot projects. Again, experts discussed and tested such activities, identified other new activities, and provided constructive insights into the use – and constraints – of such activities. OPM then adjusted and added to the list of activities that countries used – or wished to use better – based on the group break-out work and on the one-page suggestion sheets provided by experts at the beginning of the conference (details available on request).

Experts then assessed seven possible options[10] that could *potentially* be viable platforms for better learning for action between countries, where a 'platform' is a specific combination of activities hosted in a particular organisational form – such as a network, a resource centre or an observatory. Experts were invited to assess, and rank,[11] the attractiveness to them of expanding or strengthening each of those seven possible platforms using the following criteria:

- Political feasibility
- Technical feasibility
- Effectiveness
- Efficiency
- Potential for co-funding
- Financial feasibility

and within is often limited at country level (and potentially even more so at sub-national levels). 10) Technologies such as the internet can facilitate learning, but much still takes place most effectively face-to-face and through personal relationships.

[10] The seven options were: 1) A responsive fund for country-specific health system research projects. 2) Small, long-term partnership development. 3) A database for exchange of operational tools and experience. 4) Strengthening sub-regional centres of excellence. 5) African health system learning networks. 6) Strengthening the African Health Observatory. 7) In-depth evaluation of existing platforms. Details of what each of the seven options might mean in practice are available on request.

[11] In ranking their preferences, experts used a scoring system of 1–7, with 7 being their highest ranked score under any criterion and 1 being their lowest ranked score.

- Operational sustainability

Experts discussed each of the seven platforms and some provided written submissions suggesting new platforms. The seven platforms were discussed in turn in break-out groups, providing rich qualitative insights. Some experts provided submissions describing different combinations of activities into alternative learning platforms.

Experts ranked the seven possible options. They did so in terms of which options most suited the current needs of their country *and* were most feasible in terms of the seven criteria for feasibility and effectiveness cited in the bullet points above. Experts gave a score of seven (the highest score possible) down through to one (the lowest score possible) for each of the seven criteria listed in the bullet points above. Summing all the scores of all the experts then provides additional insight into which options the experts themselves thought best met their needs and were likely to be feasible and effective. Some scoring sheets are yet to be submitted, but the preliminary results based on 15 returned scoresheets are set out in the table below.

Ranking of possible options and platforms based on what experts thought best met their country needs and were likely to be feasible and effective in sub-Saharan Africa

Possible platform to support	Overall score
Strengthening sub-regional centres of excellence	462
A database for exchange of operational tools and experience	431
A responsive fund for country-specific health system research projects	397
Small, long-term partnership development	350
African health system learning networks	345
Strengthening the African Health Observatory	312
In-depth evaluation of existing platforms	262

4 Conclusion and next steps

The Second Expert Convention has further advanced understanding of how countries learn from each other and what type of learning approach could best support action. This has significantly advanced the identification of possible options to be recommended for investment. The 24 experts brought attention to particular challenges and obstacles they face when trying to learn from each other. Two-thirds of the experts also identified, in priority order, seven possible options they considered met their country needs and were likely to be feasible and effective in practice. The remaining third preferred to merge different options. In the context of a one-and-a-half-day meeting, the systematic identification, discussion, and ranking of options provides an important additional piece of information to be combined with the rest of the data gathered throughout the project. As final recommendations are put forward, it will be important to remember that three options appear to come out on top – strengthening regional centres of excellence, expanding access to operational 'how to' information, and the development of country-specific funds for locally led research.

Next steps will involve the detailed development of a set of preferred options. Analysing the information gathered during the Second Expert Meeting, OPM will now further test and narrow down the options identified and ranked in the table above and consider these alongside the submission of alternative platforms. A more developed 'business case' of three to five options will be presented to BMGF and other potential financiers early in 2018. OPM will also produce publishable articles that explain to a wider international audience what has been learned as a result of this overall assignment. In that way, OPM's articles and publications will themselves add to the knowledge about how countries can better learn from each other and put those learnings into practice.

I take this opportunity to thank all participants in the Second Expert Convention for their active involvement and contributions.

Alex Jones
Chair of the Second Expert Convention
OPM
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Annex A List of participants

Country	Name	Position/organisation
Benin	Pascal Kora Bata	Technical Adviser for Monitoring Projects – Programmes, Ministry of Health, OOAS Focal Point
Burundi	Juma M. Kariburyo	Former minister of health (and independent consultant)
Chad	Dadjim Blague	Ministry of Health, Chad
Comoros	Aboubacar Said Anli	Director General of Health
DRC	Anatole Mangala	Director of National Social Protection Programme
Ghana	Nathaniel Otoo	Former CEO of the National Health Insurance Agency
Guinea-Bissau	Placido Cardoso	Head of National Public Health Institute
Malawi	Gerald Manthalu	Deputy Director of Planning and Policy Development
Mali	Mariame Traore	Evaluation Monitoring Manager
Mozambique	Eusebio Chaquisse	Public Health Specialist, Ministry of Health
Niger	Ranaou Abache	Secretary General, Ministry of Health
Nigeria	Mustapha Jibril	Commissioner of Health, Niger State
Nigeria	Dayo Adeyanju	Former Commissioner for Health, Ondo State, Nigeria
Rwanda*	Mecthilde Kamukunzi	Ministry of Health , Rwanda
Senegal	Ibrahima Seck	Chief of Staff to State Minister of Health
Sierra Leone	Clifford Kamara	Former Director of Planning, Ministry of Health
Somalia	Adam Osman	Ministry of Health, Somalia
Tanzania	Ollympia Kowero	Former Head of Health Sector Systems Strengthening Unit and coordinator of Global Fund support, Ministry of Health
The Gambia	Abdou Salam Jatta	Economist, Ministry of Finance and Economic Affairs
Togo	Ahoefa Vovor	Director General of Studies, Planning and Health Information, Ministry of Health
Zambia	Mpuma Kamanga	Director Special Duties at the Ministry of Health

Annex B The process of developing the recommendations

This diagram shows the process of developing recommendations on how low-income countries can better learn from each other in the health sector. As explained in Section 2, the process has involved a deliberate 'funnelling' from broader reviews of the overall landscape of learning between countries through to more targeted interviews of experts (including the First Expert Convention in London) and stakeholders, as well as eight individual country case studies, culminating with the Second Expert Convention in Kigali, Rwanda on 16–17 November 2017.