Oxford Policy Management

Landscaping review part 2: What types of institutions currently facilitate learning between countries about improving health systems?

Learning for Action Across Health Systems

Nitin Bhandari, Sophie Witter, Ian Anderson and Alex Jones

May 2017

Acknowledgements

This report was produced as part of a larger project to develop recommendations on future investment in *Learning for Action Across Health Systems*, which is being implemented by Oxford Policy Management with funding from the Bill & Melinda Gates Foundation.

We would like to thank David Sanders and George Schieber for their written feedback. We would also like to thank the attendees of the project's first expert convention, who read the report in advance of the event and gave verbal feedback. As the meeting was held under the Chatham House Rule, we will not give names.

We would finally like to thank our Bill & Melinda Gates Foundation counterparts, in particular Mariam Zameer and Jack Langenbrunner, who offered regular assistance and feedback throughout.

All opinions expressed, and any mistakes, remain the responsibility of the authors.

This assessment is being carried out by Oxford Policy Management with funding from the Bill & Melinda Gates Foundation. The project manager is Alex Jones. The remaining OPM staff team members are Nouria Brikci and Matthew Roxborough. For further information contact alex.jones@opml.co.uk.

The contact point for the client is Mariam Zameer, who can be contacted at Mariam.Zameer@gatesfoundation.org.

Oxford Policy Management Limited

Registered in England: 3122495

Level 3, Clarendon House
52 Cornmarket St
Oxford OX1 3HJ
United Kingdom

Tel +44 (0) 1865 207 300
Fax +44 (0) 1865 207 301
Email admin@opml.co.uk
Website www.opml.co.uk

Abstract

Low- and middle-income countries cannot afford to waste scarce financial and human resources, and political capital, on programmes that are not effective, efficient, equitable or sustainable. There are many lessons from individual country experiences about 'what works' – and what does not work – in terms of strengthening health systems in low- and middle-income countries. But where do such countries go to if they are looking for these insights? This paper provides a rapid assessment of the various platforms that currently exist where countries can learn from one another as they undertake health system reform and strengthening.

This report is the second of three landscaping papers that lay the foundation for a larger project. The larger project will develop recommendations for the Bill & Melinda Gates Foundation (as well as the wider community) on fruitful future investment into the state-of-the-art of learning from the successes and failures of other health systems by low-income countries, and using those lessons to achieve improved health outcomes. We have termed this *Learning for Action Across Health Systems*. All three landscaping papers are available online.

Landscaping review part 1 is a review of comparative health systems literature: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-1

Landscaping review part 2 is this review of institutions and platforms that currently exist and aim to facilitate learning across health systems: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-2

Landscaping review part 3 is a review of published analyses of international policy transfer in health: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-3

Executive summary

The main objective of the review was to provide some informed – but rapid and purely illustrative – examples of the types of platforms that countries can currently use to learn from each other.

A desk-based internet search was undertaken to identify what organisations and 'platforms' currently exist to generate and share practical lesson-learning about country experiences in improving health. Findings were supplemented with expert knowledge. Particular attention – but not exclusive – was given those organisations focusing on low-income countries. The search strategy was to identify an initial, illustrative list of those organisations and platforms that: (i) have cross-country learning about health systems and outcomes as a significant – or at least explicit – part of their work programme; and (ii) then directly publish insights and lessons about improving health outcomes based on different country experiences. We identified 170 such organisations and platforms. The details are in Attachment 1[1]. We acknowledge that other organisations, including bilateral development partners, international non-governmental organisations and the media, often have a genuine interest in, and often fund, learning about cross-country differences in health outcomes. We have omitted them here as they either do not meet the two criteria of our initial search strategy or (in the case of bilaterals) are represented here by the organisations that they fund.

There were four main findings from this initial exercise. First, there appears to be a large number and a large variety of organisations that have at least some interest and involvement in cross-country learning about health systems in low-income countries.

Second, most of the organisations are based in OECD countries, although there are some 'home-grown' organisations gaining profile and credibility among emerging economies.

Third, there are quite significant definitional issues to contend with as typologies of organisations frequently overlap. There is no neat classification system and organisations – or parts of them – can often be assigned to different or even multiple categories. As just one example, the Institute for Health Metrics and Evaluation (IHME) produces and publishes comparative data on country health systems. We assigned it to the 'Institutes and Research Centres' grouping. But it could have equally been assigned to the 'University schools and faculties grouping' or the 'Think tanks' grouping. There are many other examples of overlap between groupings.

Fourth, there is little that is publicly available about the actual or potential *effectiveness* of the vast majority of the 170 organisations identified in respect to different learning domains and functions and/or whether they offer value for money. This is an important finding because decision-makers in low-income countries – and/or development partners – will find it difficult to make an objective assessment as to which organisation they should approach if they are seeking insight into the lessons from other countries. Equally, for funders, the assessment of where to invest is complicated by the lack of independent assessment of the work of most of these organisations in general and in respect to health systems in particular.

There were important limitations to the review's approach. It started with an internet search in English. As organisations are not indexed in the same way as literature, they were very hard to search through online. The review focuses on supply side, and does not capture informal networks and mechanisms. Finally, while the part of the overall project's premise is differing health outcomes across similar incomes, this review's perspective is limited to the health sector, particularly health services. It does not acknowledge the significant impact of other sectors (such as education, nutrition and sanitation) on health outcomes.

[1] Attachment 1 can be accessed here: http://opm.global/2qW0Dhf

Table of contents

List of abbreviations

AHO	Africa Health Observatory
APHRC	African Population and Health Research Center
CGD	Center for Global Development
CHAI	Clinton Health Access Initiative
CoP	Community of practice
DCPN	Disease Control Priorities Network
DFID	Department for International Development
GHO	Global Health Observatory
HPP	Health Policy and Planning
HRITF	Health Results Innovation Trust Fund
HSG	Health Systems Global
IHME	Institute for Health Metrics and Evaluation
IHP	Institute for Health Policy
OPM	Oxford Policy Management
RESYST	Resilient and Responsive Health Systems
RBF Health	Results Based Financing for Health
UHC	Universal health coverage
USAID	United States Agency for International Development
WHO	World Health Organization

1 Background

Learning for Action Across Health Systems is a collaborative effort between the Bill & Melinda Gates Foundation and Oxford Policy Management (OPM) designed to better understand how low-income countries[2] can improve their health outcomes by learning from the successes and failures of other health systems. More specifically, OPM gives an initial 'problem statement' as follows:

> *There is a clear need to understand what information policy makers in low-income countries currently want but do not have. This is particularly true now as low-income countries seek to learn the lessons of successfully and sustainably scaling up Universal Health Coverage in an era when development assistance for health is more limited. To the best of our knowledge this simple question – under what circumstances do low-income countries strengthen their health systems by learning across other health systems? – has not been asked or sufficiently interrogated …*
>
> *Perhaps most practically, comparisons between health systems may offer insights into what works best in what specific circumstances – offering policy makers useful information that can lead to better decisions. There is some evidence about 'what works' to achieve health outcomes at a technical and political economy level, particularly in middle-income countries (Shelton, 2011). But there is less up to date insight into the situations of low-income countries. Moreover, even less is known about the trajectories that countries follow in their path towards effective health systems. Understanding this demands taking a longitudinal rather than a cross-sectional perspective, acknowledging that it may not be as much about individual reforms, but about pathways of multiple reforms where extra factors such as the order, combination and timing of policy reforms can be taken into account.*
>
> *Comparing health systems offers an insight into what combinations and series of policies have led to what outcomes under certain conditions. But a broader push for improved use of comparative health system performance analysis demands more than just this. Current understanding of the transferability of this knowledge, as well as the process through which policy makers currently learn lessons from other countries, is currently lacking.*

The Bill & Melinda Gates Foundation and OPM agreed it would be useful to have as one component of this exercise an 'institutional landscape review'. This would be, in essence, an internet-based search of what type of 'platforms' currently exist that low-income countries – and their development partners – can access if they wish to learn of health system reform and strengthening from others. This paper provides the initial findings.

[2] The focus of this work is on low-income countries, which the World Bank defines as those countries with a gross national income per capita of USD1,025 or less in 2015. However, this does not exclude lesson-learning from lower middle-income economies (those countries with a gross national income per capita of between USD1,026 and 4,035) or above. Further information on the World Bank classification system is available at https://datahelpdesk.worldbank.org/knowledgebase/articles/906519

2 Aim

The aim is to generate an initial typology of which organisations and platforms are currently generating or supporting cross-country learning about health systems, particularly in or for low-income countries, and to provide illustrative examples of organisations currently active under each of those types.

3 Approach and methodology

Two principals within the OPM team led the design and write-up of the research. A postgraduate Research Assistant was appointed to undertake a rapid search of what information is available on the internet about organisations that generate and disseminate information related to cross-country learning about health outcomes, with a particular focus on low-income countries. The process started with the development of a short concept note to lay out the scope and approach to the work. This was reviewed by the wider study management group. The principals reviewed progress with the Research Assistant each week, either by Skype or email.

The methodology involved a systematic internet search. The key word used in the search was 'health systems'. In this context, health system follows the World Health Organization (WHO) definition: 'all activities whose primary purpose is to promote, restore, and maintain health'. In the case of large, decentralised countries like India, learning across large sub-units such as states was also included in our definition. The inclusion and exclusion criteria are as below.

We focus our search on the health system. However, we readily acknowledge that health outcomes differ between countries and are significantly affected by factors outside the health sector per se, including girls' education, food security and nutrition, poverty, conflict etc.

3.1 Inclusion criteria

- Organisations that: (i) have cross-country learning about health systems as a significant – or at least explicit – part of their work programme; and (ii) publish or share insights and lessons about improving health systems.
- Website with content presented in English.
- Work done since 1990 (this date was chosen to make the task manageable in the time available; it is also the notional start of the original Millennium Development Goals).

3.2 Exclusion criteria

- Comparisons of individual diseases, disease protocols and interventions (however, we do include cross country learning from vertical disease programs that affect the whole of the health system, for example HIV programs in some African countries).
- Comparisons of performance of groups of facilities (unless compared as part of a system, including referral between levels etc.).
- Comparisons of specific mechanisms (e.g. user fees) unless embedded within a wider discussion of comparative health systems.
- Data series without interpretation as performance indicators.

We acknowledge that other organisations, including bilateral and multilateral development partners such as the UK Department for International Development (DFID), the United States Agency for International Development (USAID) and the EU, often have a strong interest in financing – and themselves understanding – the lessons to be learnt from different country experiences in health reform. However, in our view bilateral organisations generally fund, or in other ways outsource, research about health systems to universities and other platforms, rather than generate and disseminate the findings themselves. As our interest is in the platforms themselves, we have chosen to exclude the bilateral development agencies.

We also recognise the 'serious' media (*The Guardian*, the BBC website, *Economist*, *Financial Times*, *Wall Street Journal* etc.) have an interest in highlighting lessons from low-income countries. However, we doubt that decision-makers in low-income countries would then approach those media sources for further advice or information, so have excluded the media. Finally, we recognise that multilateral agencies such as the International Monetary Fund have valuable and comparable statistical data on public expenditure levels and trends which are helpful in understanding the 'fiscal space' for expanding government health expenditure in low-income countries. However, in our view the International Monetary Fund does not have a specific focus on health per se so we have decided not to include it in our list of organisations.

3.3 Search and extraction methods

Search terms

The search was made using Google platform (Google and Google Scholar). We started with a scoping search using key words that would capture the widest, but still manageable, pool of organisations and platforms. This led to an iterative process whereby we refined the key words so that they became more accurate descriptions of the emerging typology. For example, our initial search for 'universities' was found to be too broad, as it covered every field and faculty. Hence, we tightened the description to 'university schools and faculties' that were specifically engaged in health outcomes or systems. The iterative process also led to deleting or redefining other categories. For example, 'fund' was too broad and imprecise a search term for this exercise: 'foundations' was a more accurate way of searching and then defining the platforms we were interested in.

Alternative spellings of key words were also used (for example 'program' as well as 'programme'). Searches were then made using combination of search terms. For example, when searching for relevant universities the following terms were used:

- 'health system' AND 'university' AND (Asia OR Africa)
- 'health system' AND 'university' AND (Asia OR Africa):.edu
- 'health system' AND 'university' AND 'Africa'
- 'health system' AND 'university' AND 'Asia'
- 'health system' AND 'university' AND 'India'
- 'health system' AND 'university' AND (low-income countries OR developing countries)
- (health system OR health policy OR health OR health system strengthening) AND 'university' AND (low-income countries OR developing countries)
- (health system OR health policy OR health OR health system strengthening) AND 'Training' AND (low-income countries OR developing countries)

3.4 Typologies

We spent a good deal of time developing a typology and classification system so that individual organisations could be grouped together in a systematic way. This proved to be a difficult part of the exercise because it was immediately apparent that the international environment is 'messy' with numerous overlapping ways of categorising organisations. For example, is the Disease Control Priorities Network (DCPN), which produces DCP 3, a project, a network, a research consortium, a think tank, or part of a university?

After discussion, we tentatively settled on 15 categories of institution where cross-country learning can occur. They are: University schools and faculties; Research centres and institutes; Research consortia; Think tanks; Scholarly journals; Communities of practice; Networks and resource centres; Partnerships and global health initiatives; Observatories; United Nations and multilateral organisations; Foundations; Projects and programmes; Consultancies; Civil society and non-governmental organisations; and Conferences. We believe these 15 types provide a useful starting point for 'mapping' those organisations that met our search criteria. We also believe these 15 categories strike the right balance between 'generalisability' on the one hand and 'specificity' on the other. That is, we have a typology that classifies the 170 organisations into groupings, but in a way that is not so general that we lose the ability to see differences between the groupings. Nevertheless, we readily recognise this is only one approach and other typologies could be equally valid. We will invite the expert group meeting of 9 May to assess the typology we used and to suggest improvements.

3.5 Qualitative assessment of the organisations

We initially sought to collect and present additional information about the relevance and effectiveness of each organisation. We therefore started to collect internet-based information for each organisation on:

- Headquarters location;
- Date of commencement of the organisation;
- Funding source and budget;
- Stated purpose and focus area and main activities;
- Geographical coverage; and
- Website and contact details.

We could identify such information for the larger, well-established organisations based in OECD countries. However, we often found it difficult to obtain this basic information for newer organisations or those in low- and middle-income countries so, in the time available, did not continue that aspect of the search.

We also sought evidence of strengths and weaknesses, and evidence of the effectiveness of each organisation. This proved to be particularly difficult as there was little if any independent assessment of how 'effective' a particular organisation might be. Few organisations had conducted – or had at least posted on their website – independent and arm's length evaluations of their work. One exception was peer-reviewed professional journals as the more established ones do have an independently produced and publicly available 'impact factor' rating. We note, however, that this is a research metric of the number of citations and not a policy impact or health system learning metric.

We did not search systematically for secondary literature focused on health system learning institutions, but, where relevant, some secondary assessments are referred to in discussing the types outlined below.

4 Results

We begin each of the 15 types with a description of that category. We then provide two illustrative examples of organisations within that category. We note that some organisations and platforms provide mainly data and analysis, while other organisations – including the multilateral development banks and global health foundations – usually provide large grant or concessional financing as well. We further note that the provision of large grant or concessional financing can either strengthen health systems to improve health outcomes or can distort priorities, depending upon how the financing is designed and implemented.

A full list of the organisations and platforms identified can be accessed here: http://opm.global/2qW0Dhf

4.1 University schools or departments

Around the world many universities have established schools, faculties, departments, programmes and colleges focusing on global health systems and health policy. These units carry out a mixture of undergraduate and postgraduate teaching as well as research. There is significant variation between schools regarding areas of speciality and how those areas are labelled. Most offer expertise in some variant of epidemiology, health policy/systems analysis, health economics, health systems management and public health. Topics such as community health, reproductive health and health informatics are also relatively common. In addition to research, it is not uncommon for schools to be commissioned by various funding bodies to conduct more routine data collection and compilation procedures, such as National Health Accounts or national surveys. They commonly try to partner with governments and non-government organisations on the ground to improve the impact of their research, as well as with other local universities and research institutions. Much of their work in cross-health system learning is conducted via teaching programmes, which bring together participants from different regions with the explicit aim of learning from one another. They overlap with other types of institutions inasmuch as they often participate within research consortia, and support and engage in communities of practice as well as journals.

While specific university departments have reputations for excellence in specific areas, their work as centres of cross-health system learning is hard to evaluate and is rarely assessed.

The Harvard School of Public Health contains nine academic departments ranging from Biostatistics and Epidemiology to Global Health and Population and Health Policy and Management. It has a significant policy focus and targets the production of global ‘health leaders’. Each department offers its own educational courses (from undergraduate level upwards, including summer schools and continuing education) and research. The school has established and hosts a number of research centres, including the Harvard Global Health Institute and the Center for Global Tobacco Control. In addition to education, research and consulting, the school plays a ‘dialogue facilitator’ role – hosting global leaders for seminars and talks, publishing a magazine and enabling interaction with the general public through online features such as ‘Ask the Expert’.

The School of Public Health and Family Medicine at the University of Cape Town contains eight divisions and four research centres. The divisions range from Public Health Medicine and Family Medicine to Health Economics and Health Policy and Systems, providing a combination of undergraduate and postgraduate education and offering both medical and academic degrees. The four research centres focus on local priority issues – infectious diseases, environmental and occupational health, health economics and women’s health. The school also has a clinical service responsibility through joint staff appointments with the Western Cape Government Department of

Health and offers consultancy services to other national government departments, international non-government organisations, trade unions and private companies.

4.2 Research centres and institutes

Research centres and institutes are similar to universities, but may have a greater focus on applied implementation (as distinct from 'pure research'). They are commonly hosted or linked with a university (or selection of universities). They sometimes also offer training, but are usually specific in their subject focus, and so limit this to postgraduate education and more bespoke short courses. These bespoke short courses often target key decision-makers, and may include workshops for government officials, for example. They can be a point of contact for local networks (both formal and informal). While they generally have some core funding, often from government and philanthropic agencies (USAID, DFID, the Bill & Melinda Gates Foundation), they may earn additional revenue from accepting commissioned work – such as bespoke policy advice. They can be influential 'thinker' organisations, but are rarely involved in the implementation of health services.

The IHME describes itself as 'an independent population health research centre at UW Medicine, part of the University of Washington, that provides rigorous and comparable measurement of the world's most important health problems and evaluates the strategies used to address them. IHME makes this information freely available so that policymakers have the evidence they need to make informed decisions about how to allocate resources to best improve population health.'[3] IHME is particularly well known for its work and publications on the Global Burden of Disease studies, which enable comparisons of health risks and health outcomes, for major disease types at a global, regional and national level and over time. IHME provides a wide range of tools and reports on cross-country health outcomes, including the Global Burden of Disease tool; data visualisation tool; country profiles; policy reports; research reports; and infographics.[4] IHME also supports the Global Health Data Exchange, a data catalogue for global health and demography. It also accepts commissioned work, such as the Global Alliance on Vaccines and Immunisation (GAVI) Full Country Evaluations.

The Institute for Health Policy (IHP) describes itself as 'an independent, non-profit research institute that works to improve health systems and social policies in Sri Lanka and the wider region. Our goals are to lead to more informed policy and thus better outcomes for all people by conducting independent research and by providing objective analysis and training, and to be a resource centre for Sri Lanka and the region.'[5] IHP has 10 specific research areas covering themes such as ageing and health, demography, health system equity, HIV, maternal health, non-communicable diseases and public sector performance.[6] IHP pays particular attention to the development and use of standardised and therefore internationally comparable National Health Accounts on the sources and uses of health expenditure at a systems-wide level. IHP is an active member of a number of prominent international health systems networks; it is co-coordinator of the Asia Pacific National Health Accounts Network and the Equity in Asia Pacific health systems research collaboration.

[3] http://www.healthdata.org/about
[4] http://www.healthdata.org/results
[5] http://www.ihp.lk/about/index.html
[6] http://www.ihp.lk/research/index.html

4.3 Research consortia

Research consortia involve multiple agents – public, private and governmental organisations, commonly universities – working together in either a formal or loose structure to pursue a common set of research objectives. We identified several illustrative examples of research consortia working on health system issues. A number of these were funded by DFID. A mid-term review of these research consortia was carried out in 2013; this concluded that the model of funding RPC for periods of five to six years has strengths in supporting longer-term capacity-building and collaborations, and provides good value for money.[7]

Resilient and Responsive Health Systems (RESYST) states that it is 'an international research consortium funded by DFID. We conduct health policy and systems research in Africa and Asia to promote health and health equity and reduce poverty.'[8] This research consortium consists of 10 agencies drawn from Africa, Asia and the UK. The 10 agencies are (in alphabetical order): AMREF Health Africa; the Centre for Health Policy, Witwatersrand University of South Africa; the Health Economics Unit, University of Cape Town; the Health Policy Research Group, University of Nigeria; the Health Strategy and Policy Institute, Vietnam; Ifakara Health Institute, Tanzania; the Indian Institute of Technology, Madras; the International Health Policy Program, Thailand; the KEMRI-Wellcome Trust Research Program, Kenya; and the London School of Hygiene and Tropical Medicine. RESYST states that it focuses research on three components of a health system. The first is financing, especially financing for universal health coverage (UHC). The second research focus is health workforce, including an emphasis on the 'lack of skilled health workers in rural areas where the vast majority of poor and disadvantaged patients live. We will also critically evaluate the role of the private sector – both commercial and not-for-profit – in training health workers in developing countries.' The third research focus is governance in the health system. This includes 'a particular interest in the relationships among frontline actors and mid-level management, and leadership in health policy implementation processes. We are working within Learning Sites located at sub-national level to: conduct action research to support local managers in taking action on issues prioritised by them and of relevance to RESYST; and to investigate critical governance issues in real time, as health system policies are implemented.'[9]

REBUILD[10] is another example of a DFID-funded RPC. It was established in 2011 and focuses on health system reconstruction post-conflict. It is led by the Liverpool School of Tropical Medicine and Queen Margaret University, Edinburgh. Partners in its first phase (2011-17) included the College of Medicine and Allied Health Sciences in Sierra Leone, Makerere University School of Public Health in Uganda, the National Institute of Public Health in Cambodia and the Biomedical Research and Training Institute in Zimbabwe. The consortium focused in its first phase on health financing research – particularly the trajectory of health financing policies post-conflict and their implication for access to services by poorer households – and health workforce reconstruction – including health worker incentive policies (their drivers and effects) and changing deployment systems. Other topics included aid effectiveness at district level, contracting policies and gender analysis. A responsive fund permitted a wider range of affiliate projects, including one on resilience in disrupted settings. Like all DFID-funded Research Programme Consortia (RPCs), ReBUILD's objectives include not only excellent research but also an impact on policy and practice and capacity-building at individual, organisational and institutional levels.

[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/493958/Health-Research-Prog-Mid-Term-Eval.pdf
[8] http://resyst.lshtm.ac.uk/about-us
[9] http://resyst.lshtm.ac.uk/research-themes
[10] https://rebuildconsortium.com/

4.4 Think tanks

Think tanks share many of the characteristics of research centres and institutions, as well as research consortia. However, think tanks also have a particular and more deliberate focus on using their research to explicitly shape and influence policy debates. A study that tried to review health think tanks in low- and middle-income countries (Bangladesh, Ghana, India, South Africa, Uganda and Vietnam) and their influence in policy change found that some of the institutes had a major impact on policy change, with active participation in policy-relevant research and advocacy. In the same study, motivation and capacity within government, political context, forms of funding, organisational and individual characteristics were found to be key factors determining the effectiveness and impact of the think tanks. Only a very few institutions were found to initiate proactive public engagement and most work was driven by requests from donors or governments. The article emphasised linkages with policy-makers, some degree of independence in governance and financing, and supportive policy environment as pre-requisites for the establishment of such institutions (Bennett, Corluka, Doherty, Tangcharoensathien, & Patcharanarumol, 2012). There are a number of rankings of northern think tanks in terms of influence, thought leadership etc, but most suffer from a clear bias in terms of who is producing the rankings. Metrics of impact are limited.

African Population and Health Research Center (APHRC). APHRC, based in Kenya, states that it is 'a leading pan-African research institution that conducts high-quality policy-relevant research on population, health, education, urbanisation and related development issues across Africa … APHRC actively engages policymakers and other key stakeholders to achieve measurable policy impacts and ensure decision making across the continent is informed by rigorous evidence-based research.'[11] APHRC focuses on five main systems issues within its policy and analytical work on health. These are: ageing and development; education; health challenges and systems; population dynamics and reproductive health; and urbanisation and well-being. APHRC received funding in 2016 from the Bill & Melinda Gates Foundation; DFID; the Ford Foundation; the MacArthur Foundation; the Rockefeller Foundation; USAID; the Swedish International Development Cooperation Agency; the Wellcome Trust; the WHO; the International Development Research Centre; the United Nations Population Fund; the Global Fund to fight AIDS, TB and Malaria; and the World Bank. APHRC publishes a wide range of journal articles and briefing notes including on health systems issues. Examples include: *Evidence informed decision-making: experience from the design and implementation of community health strategy in Kenya*; and *Moving the needle on grant absorption: insights from Africa's global fund implementing countries*

The Center for Global Development (CGD) is a think tank that has operated in Washington DC since 2001.[12] CGD generates policy-oriented research and advocacy in 12 thematic areas, including aid effectiveness; corruption, transparency and governance; gender; trade; migration; and global health. The CGD work on global health includes research and publication of books, blogs and policy working papers. Recent policy-related research on global health has included an updated version of the book *Millions Saved: New Cases of Proven Success in Global Health*.[13] CGD also produced research and policy advocacy with its report on *Priority Setting Institutions for Global Health*. CGD's priority-setting institutions for global health working group proposed the creation of a new institution to support developing countries and donors in making better informed resource allocation decisions for health care.[14]

[11] http://aphrc.org/about-us/overview
[12] www.cgdev.org/page/about-cgd
[13] www.cgdev.org/topics/global_health
[14] www.cgdev.org/topics/global_health

4.5 Scholarly journals

Scholarly journals, including those on health system issues, are distinguished by the fact that they focus on peer-reviewed original research and commentary, and seek to maintain high standards of academic rigour, scholarship and lack of bias. We identified 19 examples of scholarly journals that carried articles on health systems in low- and middle-income countries as illustrative examples of the field. Scholarly journals are often accompanied by an 'impact factor' score. This, in essence, measures 'the frequency with which the average article in a journal has been cited in a particular year'.[15] This reflects research citations but not policy impact or utility. *The New England Journal of Medicine* had the highest impact factor (59). A majority of the journals in our illustrative list are based in the UK, with a few in low- and middle-income countries. Most of these journals have global coverage, with a few concentrating on particular geographical areas. One study assessed how professional journals could make their articles more accessible and relevant to policy-makers. Recommendations included the use of a summary with policy recommendations, and enabling two-way personal communication. Similarly, the barriers to accessing journals included the absence of personal contact, the lack of relevance of research, mistrust, and power and budget struggles (Innvaer, Vist, Trommald, & Oxman, 2002). Some studies also highlight the need for clear and concise recommendations for policy-makers (Ritter, 2009).

The Lancet. *The Lancet* claims to be 'the world's leading independent general medical journal. The journal's coverage is international in focus and extends to all aspects of human health.'[16] *The Lancet* has an impact factor of 44. *The Lancet* publishes numerous scholarly articles on comparative health systems and health outcomes (as well as on other matters). As just one example,in 2013 *The Lancet* carried an article entitled *Good Health at Low Cost 25 Years On: Lessons for the future of health systems strengthening*. The article examined the experiences of countries and individual states 'which have all either achieved substantial improvements in health or access to services or implemented innovative health policies relative to their neighbours'. The countries and states were Bangladesh, China, Costa Rica, Ethiopia, Kyrgyzstan, Sri Lanka, Thailand, and the Indian states of Kerala and Tamil Nadu. It is relevant to this exercise that the authors concluded:

> *Attributes of success included good governance and political commitment, effective bureaucracies that preserve institutional memory and can learn from experience, and the ability to innovate and adapt to resource limitations. Furthermore, the capacity to respond to population needs and build resilience into health systems in the face of political unrest, economic crises, and natural disasters was important. Transport infrastructure, female empowerment, and education also played a part. Health systems are complex and no simple recipe exists for success. Yet in the countries and regions studied, progress has been assisted by institutional stability, with continuity of reforms despite political and economic turmoil, learning lessons from experience, seizing windows of opportunity, and ensuring sensitivity to context. These experiences show that improvements in health can still be achieved in countries with relatively few resources, though strategic investment is necessary to address new challenges such as complex chronic diseases and growing population expectations.*[17]

***Health Policy and Planning* (HPP).** HPP has a particular focus on health policy and planning in low- and middle-income countries. HPP states that it 'publishes high-quality health policy and systems research that aims to inform policy and practice in low- and middle-income countries.

[15] http://researchguides.uic.edu/if/impact
[16] www.journals.elsevier.com/the-lancet/
[17] Balabanova D., Mills A., Conteh L. et al. (2013). *Good Health at Low Cost 25 Years On: Lessons for the future of health systems strengthening. The Lancet*, Vol 381, Issue 9883.

Health Policy and Planning improves the design, implementation, and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high-quality research and original ideas, for an audience of policy and public health researchers and practitioners.'[18] HPP states that it has an impact factor of 2.5 and that HPP has been independently ranked 25 out of 87 in terms of health care science and service journals, and was ranked 13 out of 74 in terms of health policy and services. HPP states that its most read articles are:

- *Has India's National Rural Health Mission reduced inequities in maternal health services? A pre-post repeated cross sectional study;*
- *Review of corruption in the health sector: theory methods and interventions;*
- *Calculating QALYS [quality-adjusted life years], comparing QALY and DALY [disability-adjusted life year] calculations;*
- *The effects of global health initiatives and country health systems: a review of the evidence from HIV AIDS control;*
- *Doing health policy analysis: methodological and conceptual reflections and challenges.*

4.6 Communities of practice

'Community of practice' (CoP) is a generic term to cover broad groupings of stakeholders that share insights and exchange experiences (about health system strengthening, in this case). CoPs are usually informally structured around collaboration between individuals, compared to networks, where collaboration is typically institutional and more formalised. A systematic review to explore the evidence on the effectiveness of CoPs in the health sector focused mainly on those originating in the UK and the USA, with social interaction, knowledge creation, knowledge sharing and identity building as their major characteristics. The CoP group ranged from voluntary informal networks to formal education sessions. In terms of challenges, the study highlighted two important points: a broad range of interpretation of the CoP concept; and the importance of the role of facilitator for sustained continuity of the CoP groups (Li, et al., 2009). This was reinforced by the experience of setting up the Financial Access to Health Services in Africa CoP.[19] Despite the growth in CoPs in the health arena in recent years, there is a lack of evaluation of their effectiveness (Kothari, Boyko, Conklin, Stolee, & Sibbald, 2015). A framework for the monitoring and evaluation of CoPs in health care has been produced.[20]

Performance-based financing (PBF) CoP. One of the longer established and most active communities of practice functioning under the 'Harmonising Health in Africa' (HHA) grouping, the PBF CoP aims to bring together researchers, practitioners and policy-makers interested in performance-based financing. It maintains a website and blog,[21] but functions most commonly through email exchange. It comprises more than 2,000 members (anglophone and francophone), who share experiences, organise events, produce publications and conduct shared research. Other HHA CoPs focus on financial access, budgeting, district health systems and human resources for health, to give some examples.

[18] https://academic.oup.com/heapol/pages/About
[19] www.abdn.ac.uk/femhealth/documents/Deliverables/FH_report_CoP_finalb.pdf
[20] http://download.springer.com/static/pdf/973/art%253A10.1186%252F1478-4505-11-39.pdf?originUrl=http%3A%2F%2Fhealth-policy-systems.biomedcentral.com%2Farticle%2F10.1186%2F1478-4505-11-39andtoken2=exp=1493059687~acl=%2Fstatic%2Fpdf%2F973%2Fart%25253A10.1186%25252F1478-4505-11-39.pdf*~hmac=7ee2773ff74a757428fd7970f59cd2a2611dfeb053b7326f42a9982e853de8b9
[21] www.healthfinancingafrica.org/

Health Care Financing in Asia.[22] This is a more recent example of a CoP in the health system arena, established with similar objectives to the HHA CoPs above.

4.7 Networks and resource centres

Networks have similarities to CoPs in terms of goals; however, they tend to be more formal and based on institutional collaborations, while CoPs are often based on individuals pooling knowledge. Their focus tends to be on advocacy, knowledge sharing, training/seminar and conferences, while a number are online repositories or hubs for resources, publications and tools. Some networks, such as the Peoples' Health Movement, state that they are a 'network of networks'. In regards to their effectiveness, a recent article finds that this depends on the generation of funds, the development of interventions, and the ability to convince national government decision-makers to commit to the network's agenda (Shiffman, Quissell, Schmitz, & Pelletier, 2016).

Health Systems Global (HSG) arose out of the first Global Symposium on Health Systems Research, which was held in Montreux, Switzerland, in November 2010. HSG highlights that at that conference it was pointed out that there was no organisation for or network of health systems researchers, decision-makers and implementers to take forward health system research. As a result, consensus was reached, captured in the Montreux Statement (2010), on the need to create an international society for health systems research, knowledge, innovation and action. This society would focus on building a larger constituency and enhance the credibility and capacity for health systems research globally and in low- and middle-income countries specifically. It would be member driven and constitute the first global body fully dedicated to promoting health systems research.[23] HSG states that it is a global community of over 1,500 health systems researchers, policy-makers and practitioners. Its activities span across three broad areas of work: fostering the creation of new knowledge; supporting knowledge translation, focusing on bridging knowledge creation with practical application; and fostering research on the application of new knowledge in real-world settings. HSG claims it is 'the first international membership organization fully dedicated to promoting health systems research and knowledge translation'.[24] HSG has 10 thematic working groups generating research about health systems in countries. These focus on: emerging voices for global health; the ethics of health systems research; health systems in fragile and conflict-affected states; medicines in health systems; social science approaches for research and engagement in health policy and systems; supporting and strengthening the role of community health workers in health system development; teaching and learning health policy and systems research; the private sector in health; translating evidence into action; and quality in universal health and health care.

Health Systems Hub. The Health Systems Hub is hosted by Results for Development. The Health Systems Hub states that it is a 'knowledge and networking platform that has been designed and developed to support knowledge exchange, networking and collaboration among global health practitioners, policymakers, researchers and development partners interested in mixed (public and private) health systems … the Hub was created in response to the following challenges around mixed health systems:

- Evidence around what works is still underdeveloped (but growing rapidly);
- Some great resources exist, but they are very fragmented and widely dispersed across sectors and borders;

[22] http://healthspace.asia/group/cop-health-financing-asia
[23] www.healthsystemsglobal.org/history/
[24] www.healthsystemsglobal.org/vision/

- Few tools for organising knowledge and making it more accessible;
- Quality of evidence is very variable, so difficult to know what to trust;
- Many barriers exist between stakeholders that hinder the effective sharing of knowledge across sectors and border.'[25]

4.8 Partnerships and global health initiatives

Partnerships have similar characteristics to networks, but tend to have even more formal governance and operational arrangements. Partnerships also have much in common with global health initiatives such as the Global Fund to fight AIDS, TB and Malaria. Unlike some of the other categories, as the partnerships and global health initiatives are usually set up with a specific function and sometimes large funding commitments, there is a larger evaluative literature for them. However, these evaluations have focused on effectiveness in relation to core mandates, of which enabling learning across health systems is usually a minor component.

International Health Partnership for UHC 2030 (IHP for UHC 2030). IHP for UHC 2030 transitioned from the earlier IHP+, a partnership designed mainly to implement Paris Declaration commitments for better coordination and alignment between development partners during the Millennium Development Goals. IHP+ now gives greater focus to expanding UHC by 2030 as envisaged under the Sustainable Development Goals. IHP for UHC 2030 describes itself as 'a group of partners committed to improving the health of citizens in developing countries. Partners work together to put international principles for effective aid and development co-operation into practice in the health sector, … open to all governments, development agencies and civil society organisations involved in improving health who are willing to adhere to the commitments in the IHP+ Global Compact for achieving the health-related Sustainable Development Goals … [It] encourages increased support for one national health strategy or plan, through a work plan that ties together five technical areas, all of which are needed to harness the potential of the global aid system and improve country level health systems. The technical areas are to: (i) Support inclusive national planning processes; (ii) Jointly assess national health strategies and plans; (iii) Negotiate and agree country compacts or their equivalent; (iv) Report on progress in a more unified way, based on one common results monitoring framework; (v) Ensure mutual accountability between all stakeholders.'[26] IHP+ makes available tools for analysing and strengthening health systems including a country planning database, the One Health tool, a monitoring and evaluation platform, and a financial management assessment tool.

Results Based Financing for Health (RBF Health). RBF Health is a website and resource repository centred on one particular aspect of improving health outcomes: the use of results based financing with a particular focus on maternal and child health. RBF Health gives emphasis on using 'robust operational data and impact evaluation results' from individual country studies to improve policy and programmes. RBF Health states that 'a well-funded impact evaluation portfolio underpins HRITF's [Health Results Innovation Trust Fund's] comprehensive learning agenda, which is complemented by operational data and learning from implementation studies. The Impact Evaluation portfolio aims to capture a diversity of lessons and insights on RBF through a rich set of evaluations and analytical methods.'[27] RBF Health provides several resources to the CoP interested in results based financing including 26 impact evaluation studies from low- and middle-income countries, toolkits, and case studies. RBF Health was established in 2007 through HRITF with financial support from the Governments of Norway and the UK, and is managed by the World Bank. To date, HRITF has committed USD385.6 million for 35 RBF programmes in 29 countries

[25] http://healthsystemshub.org/about_us
[26] www.internationalhealthpartnership.net/en/faqs/
[27] www.rbfhealth.org/

and disbursed USD281.7 million. The main objectives of the HRITF are to: (i) support the design, implementation, monitoring and evaluation of RBF mechanisms; (ii) develop and disseminate the evidence base for implementing successful RBF mechanisms; (iii) build country institutional capacity to scale up and sustain the RBF mechanisms, with the national health strategy and system; and (iv) attract additional financing to the health sector. The HRITF is now transitioning to the Global Financing Facility.

4.9 Observatories

WHO states that the term 'observatory' refers to the function of monitoring health events and trends using objective and verifiable methods. Their purposes vary but the major objectives are: monitoring health situations and trends, including assessing progress towards agreed-upon health-related targets; producing and sharing evidence; and supporting the use of such evidence for policy and decision-making. The 'health observatory' concept of gathering, analysing, synthesising and sharing reliable, high-quality health information on population health and health services has become increasingly popular since the 1970s. There are now over 60 observatories functioning throughout the world, and many other platforms which perform an observatory function but are not formally termed 'observatories'. In most of these countries, observatories are sub-national (e.g. at district, regional or municipal levels). There are also a further number of subject-specific observatories which are not included in this number. Health observatories have also been set up with a decision-support function at the regional level, with WHO observatories operating in the African, Americas, Eastern Mediterranean, European and Western Pacific regions. In addition, WHO has developed a Global Health Observatory to bridge these regional counterparts.[28] The observatories are promoted as tools for learning but their performance has not been independently assessed.

Africa Health Observatory (AHO). The AHO has four functions: (i) storage and sharing of data and statistics for elaboration and download if needed; (ii) production and sharing of evidence through the analysis and synthesis of information; (iii) sustaining networks and communities, for better translation of evidence; and (iv) supporting countries in establishing national or sub-national health observatories. The AHO provides a statistical health profile for each of the 47 Member States of the African Region. AHO also produces *The Atlas of African Health Statistics* annually with data and graphs of health indicators, including health status, health systems, specific programmes and diseases, key determinants and progress on the health Millennium Development Goals. The AHO also produces the *African Health Monitor* four times a year. A comprehensive report on the health situation in the African Region is also published once every five or six years. AHO facilitates networking and information exchanges between countries in the African region. WHO is supporting certain countries in Africa to establish their own national-level observatory.

WHO Global Health Observatory (GHO). According to WHO, the GHO provides health-related statistics across more than 1,000 indicators for its 194 member states. WHO further states: 'The aim of the GHO portal is to provide easy access to country data and statistics with a focus on comparable estimates; WHO's analyses to monitor global, regional and country situation and trends … GHO theme pages cover global health priorities such as the health-related Millennium Development Goals, mortality and burden of disease, health systems, environmental health, non-communicable diseases, infectious diseases, health equity and violence and injuries.'[29] The GHO also provides a range of reports which allow analysis of comparable statistics between countries and regions over time. Reports include the annual *World Health Statistics*; (in collaboration with the

[28] www.aho.afro.who.int/en/publication/5231/guide-establishment-health-observatories-first-edition-april-2016
[29] www.who.int/gho/about/en/

World Bank) the first *Tracking Universal Health Coverage: First Global Monitoring Report*; and *Global Health Risks.*

4.10 United Nations and multilateral organisations

The United Nations, founded in 1945, currently has 193 member states. According to its website, the 'UN family' is made up of the UN itself and many affiliated programmes, funds and specialised agencies, all with their own membership, leadership and budget. The programmes and funds are financed through voluntary rather than assessed contributions. The Specialized Agencies are independent international organisations funded by both voluntary and assessed contributions. Many parts of the UN family, including the WHO, the United Nations Population Fund and the United Nations Children's Fund, directly generate data and insights into health system reform, as well as providing technical advice and programmes. Other parts of the UN family, including the United Nations Development Programme, the Food and Agriculture Organization of the United Nations, and the UN statistical division complement work on health systems. One of the key recommendations of independent evaluation was the need for UN organisations to 'deliver as one' at the country level, which would require the adoption of four principles – one leader, one programme, one budget and one office (WHO, 2012). This remains a work in progress.

Multilateral organisations – the most well known of which is the World Bank – lie formally outside of the UN system but have a global membership. As they combine grants and loans with technical advice, they can directly influence policy-makers, though this has also proved controversial in the past, with concerns about context-insensitive policies being pushed on host health systems. The regional development banks, including the Asian Development Bank and the African Development Bank, generate comparative data on public financing in their respective regions, including some aspects of public expenditure on health. However, the regional development banks have not had a consistent record in terms of providing technical assistance or concessional lending for health sector reform.

WHO. The WHO states that its primary role is 'to direct and coordinate international health within the United Nations' system'.[30] It further states that its six main areas of work are: health systems; promoting health throughout life; non-communicable diseases; communicable diseases; corporate services; and preparedness, surveillance and response. WHO has offices in more than 150 countries. WHO has a leading role within the UN system for UHC, now an explicit part of the Sustainable Development Goals. WHO supports learning between countries through several mechanisms. These include the generation and dissemination of comprehensive health data that is comparable between countries and over time, particularly through the WHO-housed Global Health Expenditure Database (GHED) and the annual *WHO World Health Statistics.* WHO also actively supports 'South–South' exchanges to facilitate learning between countries. WHO generates numerous reports and technical advice on health systems,[31] health financing[32] and UHC,[33] all of which highlight differing health outcomes by countries at similar levels of development and likely lessons to be learnt from positive 'outriders'. The annual World Health Assembly is a key point in the year for sharing the latest policy developments between WHO and a wide range of policy-makers and other partners.

The World Bank has 189 member countries and offices in over 130 countries. Since its establishment in 1947 the World Bank has financed around 12,000 projects, but since the late 1990s it has also sought to position itself as a 'knowledge bank' generating evidence and insights

[30] www.who.int/about/en/
[31] www.who.int/topics/health_systems/en/
[32] www.who.int/topics/health_economics/en/
[33] www.who.int/universal_health_coverage/en/

into the development process. The World Bank provides concessional finance, technical assistance and knowledge products in all major sectors. The World Bank has been particularly active in the health, nutrition and population sector ever since its flagship 1993 World Development Report, which highlighted, among other things, the differing health outcomes of low- and middle-income countries at similar levels of income and economic development. The World Bank states that 'the overall goal of the Bank's work in health, nutrition and population is to support developing countries in building strong and resilient health care systems; achieving Universal Health Care Coverage; and ensuring that all people have access to quality, essential health services and are not pushed into poverty because of health care costs. Key areas of focus include ending preventable maternal and child mortality by 2030; ending childhood stunting caused by chronic malnutrition; halting the spread of preventable communicable and non-communicable diseases; and increasing outbreak preparedness.'[34] The World Bank hosts the Global Financing Facility (GFF), which aims to have a financial portfolio of USD83.5 billion spread over a number of years. The World Bank states that: 'In its first year of operation, the Global Financing Facility Trust Fund supported a dozen countries representing nearly half of the worldwide financing gap for universal women's, children's, and adolescent health care.'[35] The World Bank generates and disseminates a large portfolio of research and policy advice on comparative health system outcomes.[36]

4.11 Foundations

Foundations involve private philanthropies, usually involving a family (the Bill & Melinda Gates Foundation; the Ford Foundation; the Kaiser Family Foundation; the Rockefeller Foundation). The private nature of Foundations generally allows them to be more innovative and flexible, and more willing to embrace programme risks than government, UN or multilateral organisations, and they can sometimes have a larger footprint than smaller non-government organisations. Foundations tend to put a strong emphasis on evidence-based approaches, combined with a strong sense of ensuring a business-like attitude to operations. They often fund evaluative work but their health system support is itself hard to evaluate, with limited published assessments of effectiveness.

The Bill & Melinda Gates Foundation. The Foundation has an endowment of USD39.6 billion, and USD36.7 billion in total grants have been paid out since its inception. It works in more than 100 countries. The Foundation has four grant-making areas: global development; global health; global policy and advocacy; and the United States Program.[37] The Foundation supports a wide range of health initiatives under the Global Development programme (for example, polio, vaccine development, and family planning); Global Health (for example malaria, HIV and TB); and Global Advocacy programmes (for example tobacco control, and the India programmes). The Foundation regularly supports applied research that involves comparisons of health outcomes between countries and assessing the relative effectiveness of health interventions, which is then disseminated in peer-reviewed journals such as *The Lancet.* Health systems is a new but growing area within the health portfolio.

The Clinton Foundation. The Bill, Hillary and Chelsea Clinton Foundation describes itself as a Foundation that 'builds partnerships between businesses, non-governmental organisations, governments, and individuals everywhere to work faster, better, and leaner; to find solutions that last; and to transform lives and communities from what they are today to what they can be tomorrow. Since our founding, the Foundation has focused on tackling a number of the world's greatest challenges: Global Health, Climate Change, Economic Development, Health and

[34] www.worldbank.org/en/about/annual-report/overview
[35] www.worldbank.org/en/about/annual-report/overview
[36] www.worldbank.org/en/topic/health
[37] www.gatesfoundation.org/Who-We-Are/General-Information/Foundation-Factsheet

Wellness, and improving opportunity for girls and women.'[38] The Foundation supports programmes in Africa, the Asia Pacific, Latin America and the Caribbean and in the USA. Within the Global Health portfolio is The Clinton Health Access Initiative (CHAI), established in 2002. CHAI is 'a separate, affiliated entity, that works to strengthen in-country health systems and improve global markets for medicines and diagnostics – ensuring lifesaving treatments and care can reach the people who need them the most … CHAI's goal is to transform these systems and ensure they develop into self-sustaining methods of providing low-cost, high-quality care.'[39] CHAI has eight separate work streams: access; analytics; health financing; HIV AIDS and TB; human resources for health; malaria; maternal newborn and child health; and vaccines. The Clinton Foundation publishes policy briefs and other resources that cite examples of 'good practice' in health services from which other low- and middle-income countries can learn. A recent example from Malawi involves an assessment of three different approaches to HIV treatment: multi-month prescriptions; fast-track drug refills; and community anti-retroviral therapy (ART) groups.[40] In addition to such resources, CHAI provides embedded technical staff to work in Ministries of Health; these staff members are themselves conduits to share learning across different contexts, especially in operational issues.

4.12 Projects and programmes

In contrast to established institutions and organisations such as universities, or UN organisations, there are also specialised, fixed-term projects and programmes that generate and publish lessons about health systems reform in a range of countries. The projects are usually funded by bilateral development partners and philanthropic organisations.

Disease Control Priorities. According to its website, the Disease Control Priorities Network (DCPN, funded from 2009 by the Bill & Melinda Gates Foundation, 'is a seven year project managed by University of Washington's Department of Global Health and the Institute for Health Metrics and Evaluation'. The department 'leads and coordinates two key components to promote and support the use of economic evaluation for priority setting at both global and national levels'. The DCPN is perhaps now best known for researching and publishing the *Disease Control Priorities* series. The third edition (DCP3) will introduce new extended cost-effectiveness analysis methods for assessing the equity and financial protection considerations of health and macroeconomic policies for extending coverage of proven effective interventions to prevent and treat infectious and chronic diseases, including conditions related to environmental health, trauma and mental disorders.'[41] The DCPN also has a separate programme apart from DCP3 called *Strengthening the capacity of evidence-based decision-making.* This programme conducts economic evaluation of the prevention and treatment of high burden diseases in low- and middle-income countries globally.

Evidence for Action (E4A). According to its website, E4A is a five-year programme which aims to improve maternal and newborn survival in six sub-Saharan countries: Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone and Tanzania. It claims to 'act as a catalyst for action, using evidence strategically to generate political commitment, strengthen accountability and improve planning and decision making at sub-national and national levels. E4A also works to strengthen international and regional accountability … using better information and improved advocacy and accountability to save lives'.[42] E4A is funded by DFID. The E4A programme was scheduled to end in 2016 but it

[38] www.clintonfoundation.org/about/frequently-asked-questions
[39] www.clintonfoundation.org/our-work/by-topic/global-health
[40] www.clintonhealthaccess.org/policy-brief-evaluation-of-models-of-differentiated-care-for-hiv-patients/
[41] http://dcp-3.org/about-project
[42] www.evidence4action.net/

is not clear from the website if that happened, if the programme is to be extended, or what the lessons are from its operations to date.

4.13 Consultancies

Consultancies differ from all the other typologies because this is the one category that is driven by commercial incentives and which operates on a for-profit basis.[43] It could well be argued that there is no need for this category at all, particularly because decision-makers in low-income countries are unlikely to seek out commercial companies as a basis for learning about the successes and failures of health sector reforms in other countries. On the other hand, it is clear that consultancy companies do engage directly in health sector reforms in a wide range of countries – in some cases claiming to be active in more than 75 countries – and often over a long period of time. Consultancies claim to have in-house lesson-learning and knowledge management systems that help them provide technical advice and project management based on their company's international experience. Perhaps more importantly, as bilateral development partners have increasingly 'outsourced' the delivery of analytical work on health policy to consultancies, and reduced the number of their own in-house health expertise, consultancies have become an important repository of knowledge. A number of consultancies publish their own knowledge products and insights from their experiences. While it is clear that some of this material is more akin to brand positioning and disguised advertising, it nevertheless provides some examples of cross-country experiences 'from the field', particularly in terms of real-world implementation. More significantly, as staff move from site to site, as with the CHAI embedded staff above, they share theoretical and applied knowledge across contexts, also helping clients to contextualise them.

Abt Associates is a 50-year-old company that, according to its website 'is regularly ranked as one of the top 20 global research firms and one of the top 40 international development innovators'.[44] International Health is one of 10 'practice areas'. Within the International Health practice area, Abt Associates state that they have a particular focus on maternal and child health, family planning and reproductive health, HIV/AIDS, tuberculosis, malaria and nutrition. Abt Associates further state that their 'experience providing technical assistance to strengthen core health system functions allows [them] to provide guidance on global best practices while helping implement innovative solutions tailored to each country'. Abt Associates has a website of publications and reports and 'knowledge products' drawing on country experience. The web site lists 888 separate reports on international health, including topics such as impact reports on *Uganda: Improving health and strengthening systems* and *Zambia: better health through better systems*.

Palladium has been in operation, albeit under different names, for 50 years and states it has 2,500 employees operating in more than 90 countries. Palladium has 10 'core competencies' including economic growth, environment, logistics, measuring impact, impact innovation and health. The health portfolio has six sub-sectors within the company, including health research, evaluation and learning; building resilient health systems; health markets and behaviour change.[45] Palladium also has a web-based portfolio of lessons and insights and blogs covering topics such as expanding health networks in India, matching micro financing with medical needs, and Pakistan's health system.[46]

[43] Disclaimer: This note is written by staff and consultants working for Oxford Policy Management, a consultancy itself. For that reason, we avoid profiling OPM here.
[44] www.abtassociates.com/About-Us/Overview.aspx
[45] http://thepalladiumgroup.com/capabilities/health
[46] http://thepalladiumgroup.com/research-impact

4.14 Civil society and non-governmental organisations

Non-governmental organisations are primarily focused on the implementation of programmes and advocacy but many build on their engagement in practice and policy work by commissioning, conducting, publishing and sharing reports on health system issues, usually with a strong orientation towards equity and social justice. There is little evaluation of this component; however, their mobilisation and advocacy skills mean that non-governmental organisation messages can be well transmitted, especially to civil society organisation in low-income countries.

Save the Children[47] is a children's rights-based international non-governmental organisation established in 1919. It has many partner organisations around the world gathered into one association. They state that: 'Save the Children is a global leader in improving children's health. We use evidence-based approaches to tackle life-threatening conditions, reaching as many children as possible. Since 2010, we have trained nearly 400,000 health workers and in 2013 we reached over 50 million children and mothers through health, nutrition, and HIV and AIDS programmes.' They campaign on health system issues, including vaccination, safe motherhood, ending newborn deaths, malnutrition and close to community providers, such as community health workers. Reports such as the 'State of the World's Mothers' provide comparative information on maternal and child mortality and their causes. Save the Children also campaigns on issues relating to health financing (especially on financial access to health care) and human resources for health.

Médecins Sans Frontières is a private, international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. Médecins Sans Frontières brings humanitarian medical assistance to victims of conflict, natural disasters, epidemics or healthcare exclusion. It campaigns on issues closely related to health systems, such as the right to access to medicines, and protection of health workers in crisis settings,[48] as well as conducting and publishing research on similar topics.

4.15 Conferences

Although conferences are one-off knowledge-exchange events, they are worth including as some are regular, and they create important spaces which have the explicit goal of enabling the sharing of ideas, technical information and personal contacts. Their effectiveness is, along with most of our categories, hard to assess.

Global Symposium on Health System Research

Organised by HSG, this conference takes place every two years and is one of the main global fora for sharing evidence on what works in health system development. Its website claims that: 'There is currently no other international gathering that serves the needs of this community.' The last one in Vancouver on the theme of resilience and responsiveness in 2016 attracted more than 2,000 participants. The 2018 conference will be held in Liverpool and its theme is 'advancing health systems for all in the Sustainable Development Goals (SDG) era'.[49]

[47] www.savethechildren.net/
[48] www.msf.org/en/taxonomy/term/346
[49] www.healthsystemsglobal.org/blog/208/Announcing-the-theme-for-the-Fifth-Global-Symposium-on-Health-Systems-Research.html

Prince Mahidol Award Conference

The Prince Mahidol Award Foundation[50] decided in 2007 to convene an annual international conference focusing on policy-related public health issues of global significance. The conference continues to be held every January, with specific themes for each year. The conference attracts a range of researchers and policy-makers – many by invitation but with an open call for abstracts too. Emerging infectious diseases are the focus for 2018.

[50] www.pmaconference.mahidol.ac.th/index.php

5 Summary and main findings

To our knowledge, this is one of the first 'mapping' exercises of institutions involved in cross-country learning in health systems.

There are four main findings from this initial exercise. First, there does appear to be a large number, and a large variety, of organisations that have at least some interest and involvement in cross-country learning about health systems in low- and middle-income countries.

Second, most of the organisations are based in OECD countries, although there are some 'home-grown' organisations gaining profile and credibility among emerging economies.

Third, there are quite significant definitional issues to contend with as types and organisations will frequently overlap. There is no neat classification system, and organisations – or parts of them – can often be assigned to different or even multiple categories.

Fourth, there is little that is publicly available about the actual or potential *effectiveness* of the vast majority of the organisations identified and/or whether they offer value for money. That is an important finding because decision-makers in low- and middle-income countries – and/or development partners – will find it difficult to make an objective assessment as to which organisation they should approach if they are seeking insight into the lessons from other countries. Of course, it can be argued that low and middle income countries are, in practice, likely to be influenced in their choice of advice by the profile and influence of an international organisation, including the availability of large loans and concessional financing that can often accompany such advice. Nevertheless, the fact remains that there is no easily accessible, independent, mechanism for countries to assess the actual *effectiveness* of those organisations.

Key questions for this project going forward include:

First, is this initial institutional landscape review the right approach at a strategic level? Do decision-makers in low-income countries mainly learn from one another in quite different ways, for example through their own informal networks? Second, assuming this illustrative list of typologies and organisations is a useful start to mapping the platforms facilitating cross-health system learning, is the typology we have developed broadly correct? Should the typologies be collapsed to reduce fragmentation, for example by merging the first three categories of universities, research consortia, and institutes and research centres? Or should the typologies be expanded in number to allow greater differentiation between the approaches and interests of different organisations? Is it necessary to keep refining the typologies?

Third, do the organisations that we identified capture the nature of the range of institutions and platforms currently active? Are there some that do not facilitate learning across health systems and should be removed? Are there some key institutions and platforms that we have missed?

Fourth, given this overview of the range of organisations engaged in some way in facilitating cross-health system learning, are there any apparent gaps in the market or unmet needs? Despite the apparent proliferation of organisations and platforms that generate and share information about health systems and 'good practice', is there a need for a new stand-alone organisation or platform? Or may there be a need for some form of 'clearing house' that would enable those seeking insights from country experiences to identify what is already available? Is such a 'clearing house' feasible given the strong independent positions of various international and academic organisations? In any event, it is also clear that there is no overarching global process to establish what is ''good practice'' in health system learning between countries.

Fifth, what are the practical and programming implications of this initial search for development partners (including the Bill & Melinda Gates Foundation, which initiated this exercise)? What should be done next to deepen our understanding of the institutions and platforms for learning in this field?

6 Limitations of this exercise

There are obvious limitations to the methodology. It is based on an internet search, in English, and so will miss other organisations, particularly those in low-income countries themselves with poor internet services. It also does not capture non-English speaking institutions and we found that a large number of websites from countries such as China, Thailand, Vietnam etc. were not translated into English. Conversely, considering the large presence of organisations working in health on the internet, it was difficult to create a boundary as to when to stop the search and it was challenging to ensure the reliability of information presented.

The search and analysis process was rapid, and was designed to trigger discussion rather than be conclusive in itself. It focused on the *supply side* – i.e. what organisations and types of organisations – are working to some extent on cross-country learning about health systems. We do not, at this point, address the *demand side* – what, why, how and when do policy-makers in low-income countries actually seek out and learn lessons about health system improvements. That is clearly an important consideration. Nor do we engage with the literature on 'learning health systems'[51] (what facets and features within health systems encourage them to absorb and use appropriately evidence from their own or other contexts). Furthermore, there will be other informal mechanisms for cross-country learning that do not show up on the internet, thereby limiting our mapping. These are important topics for further consideration.

Given the time available, the paper also focuses only on the ''health sector''. However, it is very clear that health *outcomes* are affected by numerous and significant forces outside of the health sector, including levels of poverty; malnutrition and food insecurity; the extent and quality of girls' education; the extent of coverage of publicly available water and sanitation; and the level of conflict in the country and its neighbours.

It is also clear from the initial mapping undertaken for this exercise that there is unlikely to be one final, neat, typology that allows organisations to be mapped without ambiguity. There is room for legitimate debate about the number and definitions of the 15 different typologies that we developed. There is also room for legitimate debate about which type any particular organisation could or should be assigned to. It is also clear that it is not possible, at least based on internet searches, to obtain an independent and reliable view about the effectiveness and impact of different organisations.

Nevertheless, we believe we have identified for the first time a reasonably broad range of organisations and typologies which have a direct or partial focus on what low-income countries and other countries can learn from one another in terms of improving health system outcomes.

[51] See, for example, www.learninghealthcareproject.org/LHS_Report_2015.pdf

References

Bennett, S., Corluka, A., Doherty, J., Tangcharoensathien, V., and Patcharanarumol, W. (2012). Influencing policy change: the experience of health think tanks in low- and middle-income countries. *Health Policy and Planning*, 27(3), 194–203.

Buse, K., and Harmer, A. H. (2007). Seven habits of highly effective global public–private health partnerships: Practice and potential. *Science Direct*, 64(2).

Haines, A., Kuruvilla, S., and Borchert, M. (2004). Bridging the implementation gap between knowledge and action for health. *Bulletin of the World Health Organization*, 82(10).

Innvaer, S., Vist, G., Trommald, M., and Oxman, A. (2002). *SAGE Journals*, 7(4), 239–244.

Kothari, A., Boyko, J. A., Conklin, J., Stolee, P., and Sibbald, L. S. (2015). Communities of practice for supporting health systems change: a missed opportunity. *BioMed Central*, 13(33).

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, M., and Graham, I. D. (2009). Use of communities of practice in business and health care sectors: A systematic review. *BioMed Central*, 4(27).

Liverani, M., Hawkins, B., and Parkhurst, J. O. (2013). Political and Institutional Influences on the Use of Evidence in Public Health Policy. A Systematic Review. *PLoS ONE*, 8(10).

Pratt, B., and Hyder, A. A. (2016). Governance of Transnational Global Health Research Consortia and Health Equity. *The American Journal of Bioethics*, 16(10), 29–45.

Ritter, A. (2009). How do drug policy makers access research evidence? *International Journal of Drug Policy*, 20(1), 70–75.

Shiffman, J., Quissell, K., Schmitz, P. H., and Pelletier, L. D. (2016). A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning*, 31(1), i3–i16.

WHO. (2012). Independent Evaluation of Delivering As One. Geneva: WHO.

World Health Organization Maximizing Positive Synergies Collaborative Group. (2009). An assessment of interactions between global health initiatives and country health systems. *The Lancet*, 373(9681), 2137–2169.