TECHNICAL REPORT
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# Creating a Pan African Network on the Use of Health Policy and Systems Research

**Stakeholders' Convening, Bellagio, Italy**
**June 26 -28, 2012**

**Report on Meeting Proceedings**
**July 24, 2012**

## ACRONYMS

| | |
|---|---|
| **ACHEST** | African Center for Global Health and Social Transformation |
| **AfHEA** | African Health Economics Association |
| **AHO** | African Health Observatory |
| **APHRC** | African Population and Health Research Center |
| **ASHGovNET** | African Health System Governance Network |
| **AU** | African Union |
| **CESAG** | African Centre of Advanced Studies in Management |
| **CHEPSAA** | Consortium for Health Policy & Systems Analysis in Africa |
| **EAC** | East African Community |
| **ECSA** | Eastern, Central and Southern African Health Community |
| **EQUINET** | Regional Network on Equity in Health in Southern Africa |
| **EVIPNet** | Evidence Informed Policy Network |
| **HPAI** | Health Policy Analysis Institutions |
| **HPEN** | African Health Policy Engagement Network |
| **HPSR** | Health Policy and Systems Research |
| **HRPI** | Health Resource Partner Institutions |
| **IEK** | Information, Evidence and Knowledge |
| **IDRC** | International Development Research Centre |
| **LMIC** | Low and Middle Income Countries |
| **NEPAD** | New Partnership for Africa's Development |
| **REACH PI** | Region of East Africa Community Health Policy Initiative |
| **RESSMA** | Maghreb Economics and Health System Network |
| **RESYST** | Resilient and Responsive Health Systems |
| **SADC** | South African Development Community |
| **SURE** | Supporting the Use of Research Evidence |

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# Creating a Pan African Network on the Use of Health Policy and Systems Research

Report on Meeting Proceedings

## I. INTRODUCTION

The health policy and systems research (HPSR) landscape in Africa has changed dramatically in the past two decades. There are a growing number of African institutions engaged in HPSR all across the continent, and a range of regional and sub-regional networks focused on strengthening data systems and analytical capacity for HPSR have emerged. Additionally, regional and sub-regional intergovernmental bodies are increasingly facilitating high-level discussions on health systems and policy issues. These institutions and initiatives have collectively made a tremendous contribution to enriching the evidence-base for health systems management and reform on the continent, and have fostered dialogue and debate on health policy issues in Africa.

Despite the progress that has been made, key stakeholders on the continent perceive that poor integration and under-use of HPSR in the policy process remains a critical gap. Several factors contribute to this knowledge translation gap. On the supply side, researchers tend to favour academic research on topics that are publishable in international peer-reviewed journals using primary data collection techniques; less attention is given to applied analysis that either synthesizes large bodies of academic literature to distil key insights or uses secondary data to rapidly investigate policy issues of immediate relevance to national and regional stakeholders. While researchers are well trained to write journal articles, they may not have the requisite skills to produce diverse dissemination products that are more accessible to non-technical audiences, as well as engage in and facilitate policy dialogues with different stakeholders and interest groups. Links between researchers and knowledge translators, like the media and civil society advocacy groups, remains weak in most African countries. On the demand side, policy-makers rarely ask for evidence to design new policies and review existing ones, which could be the result of a variety of factors including lack of access, poor understanding of the value of research, and absence of societal norms that require policy to be based on evidence. Additionally, there is at present very little coordination between various actors, regional bodies, thematic networks and intergovernmental bodies working to strengthen the evidence-base for health systems and health policy. There is no central repository for HPSR from across the continent, nor is there a formal mechanism for this evidence to inform pan-African discussion about health policy priorities.

Against this backdrop, the Rockefeller Foundation and ThinkWell (formerly known as the Institute for Collaborative Development) jointly hosted a 3-day consultative meeting on June 26-28, 2012 at the Rockefeller Center in Bellagio, Italy to discuss a pan-African network for promoting the use of health policy and systems research (HPSR) in the policy process. Participants at the meeting included health policy and systems researchers, representatives from regional intergovernmental bodies, government officials, and development partners. The goals of the consultation were to

- Arrive at a common vision for a network of existing African institutions and networks that would strengthen the link between the HPSR community and policy-makers in Africa,
- Discuss the proposed network's scope of work as well as its organizational and governance structure,
- Agree on a process for forming the network.

In the months preceding the meeting, ThinkWell undertook a desk review of the field of HPSR as well as a landscaping exercise to identify African institutions that are actively engaged in HPSR. Day 1 started with a presentation of the findings from the landscaping exercise followed by a detailed discussion about the kinds of work that different African institutions and networks represented by the meeting participants were undertaking. Participants reflected on key challenges impeding the use of health systems evidence in policy-making on the continent.

On Day 2, meeting participants worked in groups to develop their vision for a pan-African network on health systems. Participants offered a variety of perspectives on how the gap between the generation of HPSR and its use by policy-makers and health system actors could be bridged. The deliberations eventually converged around two models for HPSR knowledge translation. The first model envisaged a network that would focus on integrating research into the policy process at the country-level, typically by building links between national research institutions, knowledge translators like the media and policy advocacy groups, and policy-makers. A second continental perspective emphasized the need for a pan-African platform on health systems structured around existing continental and regional intergovernmental organizations as well as existing networks to coordinate and facilitate work on health systems and health policy issues at the national, regional, and continental levels.

**Further discussion about the complementarities between the two models resulted in a decision to unify them into a single Pan-African Network on Health Policy and Systems Research that will serve as a forum that aggregates health systems and health policy knowledge from across the continent, and advocates for its use in national, regional and continental policy-making and implementation. A working group was set up to facilitate the creation of the pan-African network, including developing a detailed proposal on the core mission, operating structure, and governance framework for the network.**

This report documents proceedings at the meeting. It is not intended to serve as a complete record of the rich discussion that ensued over the course of the 3-day meeting. Instead, it summarizes key points of discussion and decisions from the meeting so as to serve as a guide for future work. Section 2 briefly describes the meeting participants. Section 3 captures the main insights that emerged from the discussion about the current status of HPSR in Africa and the experience of existing networks and institutions working

on health systems issues. Section 4 describes the vision for a network for promoting the use of HPSR in the policy process in Africa. Section 5 concludes by documenting the agreed upon next steps.

## II. CONSULTATION PARTICIPANTS

Meeting participants included researchers from 9 African institutions engaged in HPSR: the African Population and Health Research Center (APHRC), the Health Economics Unit at the University of Cape Town, KEMRI Wellcome Trust Research Program, the African Center for Global Health and Social Transformation (ACHEST), Makerere University School of Public Health, Noguchi Memorial Institute for Medical Research at the University of Ghana, the Institute for Statistical, Social and Economic Research at the University of Ghana, the African Centre of Advanced Studies in Management (CESAG), and the American University in Cairo. Pan-African and regional intergovernmental bodies working on health systems issues were represented by the African Union Commission, the New Partnership for Africa's Development (NEPAD), the West African Health Organization (WAHO), and the Eastern, Central and Southern African Health Community (ECSA). Development partners present at the meeting included the World Health Organization (AFRO office), the International Development Research Centre (IDRC) in Canada, the Bill and Melinda Gates Foundation, and the Rockefeller Foundation. A member of the board of the African Health Economics Association (AfHEA), a government official from Ghana, and a retired World Bank staff who was engaged in the formation of the Asia Pacific Observatory on Health Systems and Policies also attended the meeting. The ThinkWell team facilitated the meeting proceedings. A complete listing of participants with contact information can be found in Annex A.

## III. HPSR IN AFRICA

The landscaping exercise conducted by ThinkWell and the Rockefeller Foundation in the lead-up to the meeting focused on understanding the current state of HPSR in Africa and the knowledge translation gap as it relates to health systems issues. The goals of the exercise were to map the terrain in terms of institutions and networks engaged in HPSR; gather feedback on the critical gap between evidence generation and its use for policy-making; and explore the idea of creating a pan-African network to address the evidence to policy gap. The study was envisioned as a landscaping exercise rather than a formal research project. The team undertook a comprehensive desk review of the literature on defining HPSR, the status and role of HPAI and technical networks especially in Africa, and the topic of linking evidence to policy-making to distil key insights to inform the discussion at the consultation. They also conducted in-person and phone interviews with key informants from HPSR institutions, technical networks, regional bodies, governments, intergovernmental bodies, civil society advocacy groups, donor agencies, and key health sector stakeholders in Africa (the background paper is included in full in Annex B).

The presentation of the findings from the exercise on the first day of the consultative meeting stimulated an informative discussion about the status of HPSR in Africa. Meeting participants from various African institutions shared information regarding their own work in the HPSR domain, their perspectives on the issue of knowledge translation and associated challenges, as well as their experience working in networks in Africa. Some of the main themes to emerge in the course of the discussion about the HPSR landscape and the knowledge translation gap are summarized below:

- Strong governments are essential for strong and well-functioning health systems. However, governments do not work in isolation. In both supporting governments and in holding them accountable for their performance, non-governmental actors play a vital role. Hence, in order to strengthen health systems, we need to think about how we can foster greater synergy between country governments and "health resource partner institutions" such as universities, NGOs, CSOs, research institutions, advocacy groups, professional organizations, private sector actors, etc. in their respective countries.

- Health policies in Africa are made at continental, regional, and national (and sub-national) levels. While the bulk of policy-making and policy implementation is a national process, regional and continental bodies in Africa play a critical role in setting policy agendas and influencing national policy outcomes, as well as in representing the African perspective in global discussions. Consequently, we need to think about knowledge translation to bridge the gap between the research community and policy-makers at all levels. The country-level interventions to better integrate the research and policy processes might be of greater impact in some situations in some countries (for example in South Africa where there is a large pool of national HPSR researchers and they already have established links with health policy actors), while infusing research evidence into regional and continental debates on health systems via intergovernmental bodies may prove to be an effective way to influence the national policy agenda in others.

- The need for knowledge translation is widely recognized. Many institutions represented at the table are already engaged in efforts to address the knowledge translation gap in their specific focus areas. However, at present there is no single institution or initiative focused squarely on knowledge translation for HPSR.

- Bridging the HPSR knowledge translation gap is essentially about bringing the supply and demand for HPSR together. Supply-side interventions to bridge the gap that are primarily driven by researchers run the risk of losing sight of the demand-side of the equation. Hence, making sure that the end-users of this information and the target audience are well represented in the governance structure of any new network or platform is critical.

- The target audience/consumers of HPSR are diverse. It includes knowledge translators, like media and advocacy groups, as well as policy makers. Researchers or knowledge producers will need to think creatively about different ways to reach them. Researchers are trained to do analytical work. Policy engagement involves new skills. Hence researchers may need additional capacity building in areas such as policy communication, stakeholder engagement, etc.

- Any additional applied policy analysis and engagement work has to be balanced with the reality of current HPSR resources in Africa. Despite a tremendous growth in HPSR capacity in Africa, the pool of researchers still remains small and they are all stretched thin. More thought needed on how we can accommodate the additional work that knowledge translation requires.

- Making research more responsive and relevant to the policy making process requires relationship-building between the research community, knowledge translators, and policy-makers. This takes time. Greater funding for such activities is needed.

- Any initiative on HPSR has to carefully consider definitional issues related to health and health systems. There is a need to expand "health" from being narrowly focused on health services and outcomes to include the social determinants of health. It should be noted that the health system building blocks framework, though widely used, does not do justice to the complexity of the health system. There is ongoing work led by WHO to track HPSR by institutions in low and middle income countries and define HPSR, which will be discussed at the 2012 HSR symposium in Beijing. These are valuable resources that can guide any Africa-focused initiative on HPSR.

- The landscaping exercise focused on 14 institutions engaged in HPSR from 8 African countries. Expanding the landscaping work to identify more institutions in other countries would be valuable in terms of making the network truly continental.

- When the research process is completely external to the policy process, we run the risk of research having little to no relevance. If the research agenda is driven entirely by the policy process, then research may overlook important issues that affect people but are not on the policy agenda. We need to find the right balance between the two extremes.

- Finding timely and high-quality data on health and health system performance in Africa still remains a challenge. Any comparative analysis will need a strong foundation of comparable data. This is an area that requires greater attention.

Many of the participants at the meeting shared their first-hand experience of forming and working within networks in Africa. They reflected on the benefits and challenges presented by multi-country African networks working on health systems issues. Some of the key insights about the formation of a new network for the policy use of HPSR are summarized below:

- Formation of any network or platform in Africa should be African-owned and African-led in order to establish sustainability and a demand-led agenda from the outset.

- There are many existing networks active in a variety of thematic domains. Some that have direct relevance to this initiative include AfHEA, EVIPnet, ASHGovNET, and CHEPSAA. We need to make sure that any new network that is formed to promote the use of HPSR leverages the work of these other networks, avoids duplication, and adds tangible value to the field.

- There is a widely perceived need for greater coordination between the existing networks that enhance health systems information and data flows, build and leverage capacity for health systems and health policy analysis, and produce HPSR. Hence, this new initiative could serve as a network of networks.

- The governance structure of the network, which should follow from its overall vision and mission, will determine how well the network performs. Hence, care and

deliberation need to go into setting up the governance structure of the network.

- While networks are good for fostering linkages between researchers, having a strong local presence is critical to influencing national policy processes.

- Ensuring equal participation by all African institutions can be a challenge, which often results in the countries and institutions with greater capacity and interest carrying a heavier burden.

- There has been a long history of networks coming into existence and dying in Africa, often because initial donor funding for the effort comes to an end. Hence having a resource mobilization strategy that combines catalytic funding from donors with longer term local financing from government and other resources is critical.

- All relevant stakeholders have to be involved in the process of setting up the network or there is a risk of them not wanting to partake of "a meal that has already been cooked." In this case, the key stakeholders are HPSR institutions, intergovernmental bodies, existing networks, African governments, donors and civil society actors. Involving all of them from the start is vital.

- The network should ideally have some standardized methods and products. The experience of the European Observatory and the Asia Pacific Observatory is instructive in this regard; they both adopted a standard approach/format to undertake health systems assessments in every country. These assessments then serve as the basis for comparative analysis and policy analysis. Additionally, ensuring consistent quality is important.

## IV. A PAN-AFRICAN NETWORK FOR HEALTH POLICY AND SYSTEMS RESEARCH

In discussing the vision for a pan-African network for HPSR knowledge translation, diverse perspectives were expressed on what the goals and structure of the network should be. Below, we briefly describe the two main models that emerged from these discussions – the continental model and the national model. Next, we summarize the discussion about how the two can be integrated into a common platform.

### The Continental Model

This approach focuses on building a pan-African platform to bring together all actors – existing networks and individual institutions – working in the field of health systems in order to increase synergies in health systems policy development and implementation.

The platform's main objectives would be to:

- Promote collaboration, coordination, and synergy between African institutions and initiatives working on health systems issues
- Serve as a conduit for research and evidence to guide health policy discussion, debate, and development
- Accelerate the implementation to scale of existing African and other policy instruments through advocacy campaigns and monitoring of the implementation process
- Support Africa's engagement with the global health community
- Provide an integrated, holistic approach to MDGs and health in general

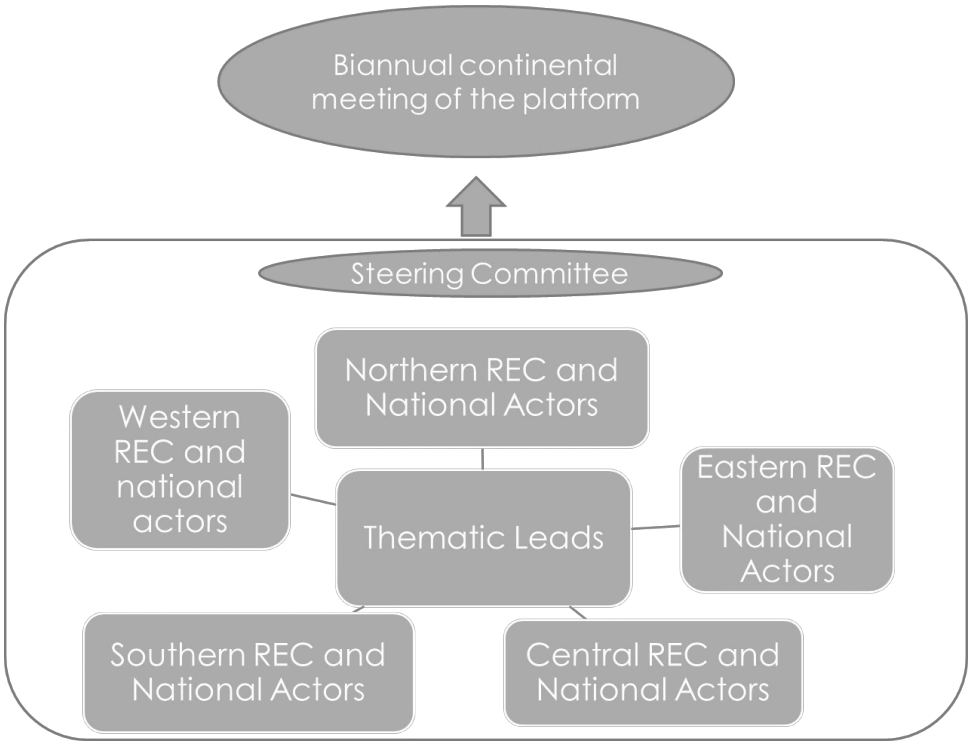


**Figure 1: Proposed Structure of the Continental Platform for Health Systems**

Figure 1 depicts the proposed structure of the platform. Activities of the platform would be organized within regional zones under the guidance of regional economic communities like WAHO and ECSA, and would be coordinated by thematic leads based on the WHO health systems building blocks (financing, governance, access to medicines and commodities, quality of care, health workforce, ICT for health, and communication and advocacy). The leads for the thematic areas will be drawn from existing institutions and networks; e.g. AfHEA for health financing, ASHGovNET for governance, leadership and management, NEPAD for access to medicines and commodities etc. A steering committee would oversee the working on the platform and organize a biannual continental meeting to coincide with the African Union Ministers meetings.

### The National Model

The national model focuses on bridging the research to policy gap at the national level by strengthening linkages between researchers, knowledge translators, and policymakers, and leveraging regional and continental bodies to influence national, regional, and continental policies. The network would be formed by a nodal HPSR institution from each country that in turn will build linkages with other national HPSR institutions, knowledge translators and policy makers at the country-level. The network, through its governance structure, would liaise with regional and continental bodies.

The network would, first, strengthen relationships among key actors along the knowledge translation continuum, including health systems and policy researchers, research to policy translators (media, advocacy groups, civil society groups, etc.) and policy makers. Activities to achieve this objective include:

- Create forums for relationship-building between researchers and policymakers
- Convene workshops bringing together key actors in the research to policy continuum on specific topics

- Promote full use of modern media to facilitate dialogue between key actors in the research to policy space
- Organize study tours for key actors
- Promote joint appointments of researchers in government-led working groups and committees as well as policymakers in research institutions to foster greater understanding
- Promote policymaker sabbaticals / honorary appointments at research institutions

Second, the network would further facilitate knowledge translation for policy and practice through activities such as:

- Training of researchers / communication officers / media officers to improve knowledge translation efforts for different audiences
- Training policymakers on the uses of multi-disciplinary evidence in decision-making
- Helping policymakers to formulate policy-relevant research questions
- Promote regular policy dialogues
- Share research products and experiences
- Organize programs for media and CSO interested in knowledge translation
- Evidence synthesis to identify gaps
- Identify and advocate for new funding streams for knowledge translation

Lastly, the network would serve as a platform for cross-country information sharing and learning. As such, the network would be tasked with the following activities:

- Organizing international conferences on priority issues
- Commissioning secondary studies (comparative research, good practices in research and policy)
- Developing appropriate tools for regional studies and create consensus on common methodology for cross-country comparisons
- Convening experts to guide development of research questions and policy development
- Contributing to generating standards
- Promoting a repository of research (standardized cross-country comparisons, commissioned analysis)
- Making use of modern media for wide dissemination of information across the continent

### The Combined Vision for a Pan-African Network on Health Policy and Systems Research

Recognizing that the continental and the national models that emerged in the course of the discussions are complimentary and aim to achieve the same ultimate goal of fostering evidence-based health systems policy, most participants at the meeting agreed that they should be combined to form a single Pan-African Network on Health Policy and Systems Research.

The proposed network would address the research to policy gap and the policy to implementation gap at the national, regional and continental levels. The common objectives that emerged from the two models that would be the focus on the network's efforts are listed below:

- Establishing a mechanism for policymakers, knowledge translators including media and civil society, and researchers to work with a common agenda
- Facilitating knowledge translation and sharing, thereby translating research findings into policy & programs

- Providing a cross-country learning platform that informs policy debates at the national and regional level
- Identifying and addressing knowledge gaps using research that applies multidisciplinary approaches
- Influencing health systems data quality and access
- Promoting implementation and monitoring of existing African policy instruments

The unified model would be structured as a network of existing networks and institutions. It would build on pre-existing strengths within these entities, and interact with policy bodies on the continental level. The model would maintain in-country presence through national researchers. Participants identified several issues that would need to be addressed to make the network a reality. These included:

- Defining the exact nature of the new entity (including whether it is a network or a platform)
- Defining membership (individuals or institutions) and a selection process for the key roles
- Developing a suitable operating structure with effective leadership for the entity that leverages existing institutions and networks without making the new entity administratively complicated
- Designing a governance structure that provides direction and oversight
- Clearly articulating the continental-, regional- and country-level activities the entity will undertake under each objective
- Ensuring all relevant stakeholders are consulted so as to secure their buy-in
- Securing sufficient funding to make the entity sustainable while also ensuring African ownership
- Avoiding the conceptual silos between the health systems building blocks in order to foster systems thinking and to make the entity flexible to address emerging issues
- Ensuring both a regional/continental role and a strong country presence
- Adopting an incremental approach whereby the new entity can be initiated quickly with low levels of funding, and scaled-up incrementally as it achieves results

## V. NEXT STEPS

Several African institutions and stakeholders present at the consultation formed an interim working group to further develop and refine this idea. These included Allie Kibwika-Muyinda (Chair), Francis Omaswa, Fredrick Ssengooba, Sherine Shawkey, Edward Kataika, Caroline Kabiru, Chris Zeilinski, Kubata Bruno Kilunga, Daniel Arhinful, Issiaka Sombie, Felix Asante, and Amani Koffi (Vice chair).

Upon completion of the draft report of the consultation proceedings, the Interim Working group will follow up on the following:

1 Finalize report of consultation proceedings and disseminate report

2 Define Terms of Reference and a timeline for the Interim Working Group

3 Develop a strategy for broader consultation with other institutions and regional communities, including those invitees who were unable to attend the consultation and share draft report of conference proceedings for comment with broader network.

4 Identify other relevant forums for enhancing buy-in

5 Appoint leadership and select a driving institution for the network/platform

6 Refine core institutions and submit a governance structure

7 Develop a constitution, operating model, and by laws

8 Establish network identify/visibility (website, logo, etc.)

9 Develop a business plan/proposal, work plan

10 Develop resource mobilization strategy, identify interim resources to drive working group.

## ANNEX A

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## ANNEX B

### THE BACKGROUND PAPER

### I. INTRODUCTION

Over the last decade, the world has seen dramatic developments in health systems across Africa. Ghana and Rwanda have scaled up health insurance to cover large proportions of their populations, performance-based financing has been introduced at scale across the continent, new policies legitimizing the role of community health workers in Ethiopia and Madagascar have formalized a new cadre of health workers, and innovative technologies have transformed referral and reporting systems. As lead countries in Africa continue to develop health systems innovations, and peer countries follow suit, it is critical that inter-country dialogue and cross-country comparisons are leveraged to inform and guide health policy.

Many health policy analysis institutions (HPAI) have begun to emerge in Africa, such as the Health Economics Unit at the University of Cape Town, the African Centre for Health and Social Transformation (ACHEST), and African Population and Health Research Center (APHRC), to name a few. Additionally, regional and sub-regional networks focused on strengthening data and analysis on health systems issues have also emerged on the continent; the African Health Observatory (AHO) hosted by WHO's Regional Office for Africa, the African Health Economics Association, the Regional Network on Equity in Health in Southern Africa (EQUINET), the African Health System Governance Network (ASHGovNET), the Evidence Informed Policy Network (EVIPNet), the Supporting the Use of Research Evidence (SURE), the Region of East Africa Community Health Policy Initiative (REACH PI), and the Consortium for Health Policy & Systems Analysis in Africa (CHEPSAA) are all examples of networks that are engaged in generating and synthesizing evidence about health systems and/or facilitating dialogue on health policy issues in different ways.

Alongside these technical agencies and networks are regional and sub-regional intergovernmental bodies and economic communities that facilitate high-level discussions on health systems and policy issues. The African Union (AU) is a pan-African body with the mandate to convene African governments to discuss economic, political and social issues, with the New Partnership for Africa's Development (NEPAD) serving as its technical and program implementation arm. Regional intergovernmental bodies focused on health like the Eastern, Central, and Southern African Health Community (ECSA) and the West African Health Organization (WAHO) as well as regional economic communities like the East African Community (EAC) and the South African Development Community (SADC) also foster intergovernmental dialogue and cross-country learning on health policy issues within their regional spheres of influence.

These existing HPAI, networks, and intergovernmental bodies have made tremendous contributions to both enrich the evidence-base for health and health systems, as well as to facilitate dialogue on health policy issues in Africa. Despite the progress that has been made, key stakeholders on the continent – the aforementioned groups as well as policy-makers and health program managers – perceive that under-use of health policy and systems evidence in the policy process remains a critical gap.

Several factors contribute to this gap. First, researchers tend to favour academic research on topics that are publishable in international peer-reviewed journals using primary data collection techniques over applied analysis that either synthesizes large bodies of academic literature to distil key insights or uses secondary data to rapidly investigate policy issues of immediate relevance to national and regional stakeholders. Second, while academics are well trained to write journal articles, they may not have the requisite skills to produce diverse dissemination products that are more accessible to non-technical audiences, as well as engage in and facilitate policy dialogues with different stakeholders and interest groups. Third, despite the progress that has been made in terms of creating resources for health policy and systems research (HPSR) on the continent, overall capacity still remains low and is concentrated in a few African countries.

Fourth, policy-makers are not demanding or accessing evidence to guide their decision-making, which could be the result of a variety of factors including lack of access, poor understanding of the value of research, and absence of societal norms that require policy to be based on evidence. Fifth, there is at present very little coordination between various actors, regional bodies, thematic networks, and intergovernmental bodies working to strengthen the evidence-base for health policy. There is no central repository for HPSR from across the continent, nor is there a formal mechanism for this evidence to inform pan-African discussion about health policy priorities.

The Rockefeller Foundation and ThinkWell have jointly undertaken a landscaping exercise in order to better understand the current state of HPSR in Africa and the challenges summarized above. The goals of the study were to map the terrain in terms of institutions and networks engaged in HPSR; gather feedback on the critical gap between evidence generation and its use for policy-making; and explore the idea of creating a pan-African network to address the evidence to policy gap.

Based on the feedback received, we propose to form the African Health Policy Engagement Network (HSPEN) for promoting the use of HSPR for policy-making in Africa. The network will be pan-African in nature, and will be both steered and operated by African institutions and stakeholders. It will link and leverage existing African HPAI, networks, and regional bodies to undertake activities to serve the following functions:

- Generate applied research and policy analyses on health systems issues that are relevant to on-going national and regional discussions on the continent, draw on existing data and literature in order to respond to issues in real time, and clearly articulate policy recommendations
- Promote active engagement with policy-makers by building the knowledge translation capacity of analysts, especially in the areas of disseminating information and research findings using diverse means, engaging with the media, and hosting policy dialogue
- Contribute to pan-African discussions on health policy issues by aggregating, synthesizing and channelling up-to-date and relevant evidence on health systems and policy issues to regional and sub-regional bodies that have the mandate to convene high-level policy-makers and facilitate cross-country dialogue on health policy issues
- Serve as a repository for HPSR from across the continent

In order to discuss the findings from the scoping exercise as well as the proposed pan-African network, the Rockefeller Foundation and ThinkWell have convened a consultation of key stakeholders in Bellagio, Italy, from June 26-28$^{th}$ of June. The goal of this background document is to:

- Review the key findings from the landscaping study
- Articulate a vision for the proposed network
- Articulate key questions about the scope and structure of the network for further discussion at the consultation

## II. METHODS

This investigation was envisioned as a landscaping exercise rather than a formal research project. We used the following two approaches to gather the information presented in this document:

- Desk review of the literature on defining HPSR, the status and role of HPAI and technical networks especially in Africa, and the topic of linking evidence to policy-making
- In-person and phone interviews with key informants from African HPAI, technical networks, regional bodies, government officials, African intergovernmental bodies, civil society advocates, donor agencies, and key health sector stakeholders.

Like all studies, this one suffers from some limitations. We recognize that we have not contacted an exhaustive list of institutions, networks and regional bodies active in Africa. Our method for finding institutions favors those that have a web-presence. Also, our sample is inadvertently biased towards English-language institutions.

## III. DEFINING THE FIELD OF HEALTH POLICY AND SYSTEMS ANALYSIS

Various definitions have been proposed for the closely-linked fields of health systems research, health policy research, as well as the combined domain of health policy and systems research (the terms analysis and research are used interchangeably here). Below, we discuss key distinctions and definitions as they pertain to this current study.

**WHO (2009)** defines health systems research as "the purposeful generation of knowledge that enables societies to organize themselves to improve health outcomes and health services." **Mills et al (2008)** define health systems research as "concerned with how health services are financed, delivered and organized, and how these functions are linked within an overall health system with its associated policies and institutions." **Gilson (2012)** further notes that health systems research focuses on both health systems, examining issues in one or more of the six building blocks of the health system (health financing, governance, health workforce, health information systems, service delivery and medical technologies), as well as interventions for strengthening health systems and health system performance.

Policy analysis in general is defined as the study of the policy process, which has traditionally been envisioned as consisting of the following four stages: agenda setting, policy formulation, implementation and review (Laswell 1956). Theorists have since criticized the linearity of this stages framework, suggesting other heuristics for understanding the policy process. Health policy has been defined as "courses of action (and inaction) that affect the sets of institutions, organizations, services, and funding arrangements of the health system" (Buse, Mays and Walt, 2005). The predominant health policy research framework proposed by Walt and Gilson (1994) emphasizes the interaction between the technical content of the policy, health system actors, the policy context and the policy process.

The domain of HPSR, which combines the two areas mentioned above, is defined as "research on the policies, organizations, programs, and people that make up health systems, as well as how the interactions amongst these elements, and the broader influences over decision making practices within the health system, influence system performance" (Gilson 2012). The fact that health policies act on health systems and are in turn influenced by the very institutions and actors that comprise the health system is the rationale for combining these two traditions of inquiry.

Defined as such, HPSR does not include basic scientific research on products and technologies, assessing clinical efficacy or effectiveness of particular treatments or technologies, or the measurement of population health profiles and patterns. It is multidisciplinary, drawing perspectives and diverse research methods from the fields of economics, anthropology, political science, sociology, as well as public health (Gilson 2012).

| Paradigm of knowledge | Purpose | Research strategy | |
|---|---|---|---|
| | | *Collection of new data* | *Analysis of existing data* |
| **Positivist** | Explanatory | Experimental and quasi-experimental design including, for example, before and after studies | Simple and multiple-variable modelling |
| | Descriptive | Survey designs: questionnaires, interviews and indirect observation;<br>Repeated surveys to allow trend analysis over time | Secondary data analysis (census data, record data)<br>Quantitative content analysis (newspaper reports, speeches, etc.) |
| | Exploratory | Survey designs (pilot studies) | |
| **Relativist** | Explanatory | Case study (theory building, longitudinal)<br>Grounded theory (theory building) | Qualitative content analysis<br>Discourse analysis<br>Historical analysis |
| | Descriptive | Case study<br>Ethnographic designs with the focus on unstructured direct and indirect observations, for example narrative inquiry, critical ethnography | |
| | Exploratory | Field designs or ethnographic designs with the emphasis on the use of informants, for example autho-ethnography, autobiography, life histories<br>Case study (such as generating categorizations)<br>Qualitative interviews and panels | |

Source: Lucy Gilson, 2012.

Unlike biomedical, clinical and some social science research paradigms that focus solely on the positivist tradition of hypothesis testing, health policy and systems research can be positivist or relativist (the positivist approach views particular social phenomena or outcomes as manifestations or observations of a single reality or a general phenomenon and holds that the latter can be discovered through the study of the former; the relativist approach views social outcomes as a function of particular actors and contexts, and does not hold that there is a single reality underlying them) (**Gilson et al. 2011**). HPSR could be exploratory, descriptive, or explanatory/evaluative. Lastly, it could entail primary research based on the collection of new data or secondary analysis of existing data and literature. Gilson (2012) provides a framework for categorizing study designs (see table above).

In addition to the secondary research strategies mentioned in the table that use existing data, there are research syntheses techniques that summarize or interpret existing studies. Both systematic reviews and meta-analyses summarize findings from a carefully selected set of studies examining a common question, with the latter typically using statistical methods to measure a generalizable effect from a group of quantitative observational studies (**Alliance 2009**). They both stem from the tradition of assessing the efficacy and effectiveness of clinical interventions, which is typically of interest to clinicians. In contrast, alternatives techniques have been suggested to respond to other types of questions that may be of interest to policy-makers and health program managers. For example, policy makers might be interested in a literature review summarizing everything we know about a particular policy question or problem, or an analysis of the contextual factors influencing a particular policy action **(Lomas 2005)**. As a group, these

syntheses methods respond to the needs of policy-makers, managers as well as clinicians and researchers to have a large and growing body of literature summarized in different ways (**Lavis et al, 2006**).

Besides these general summative methods that find application in health research more broadly, HPSR has also developed the tradition of health systems profiles or health systems assessments that provide a comprehensive overview of all health system areas in a particular country at a given point in time using diverse sources of information. They draw from existing studies and reports, secondary data sources, key informant interviews, and stakeholder consultations to provide a thorough assessment of all health sector domains as well as key health sector reforms for a country at a given point in time. The **European Observatory** for Health Systems and Policy pioneered the standard Health Systems in Transition report format, which it has used to systematically review health system performance in European countries at regular 3-5 year intervals. The newly established **Asia Pacific Observatory** for Health Systems and Policy has adopted the same template to systematically review health systems in its region. The USAID-funded Health Systems 20/20 project has developed the **Health Systems Assessment** approach, and undertaken assessments in several African countries. The **African Health Observatory** hosted by WHO's African Regional Office (WHO AFRO) is developing country health systems profiles for each of its member countries.

In sum, the field of health policy and systems research is one in flux. Champions for this domain of research are challenging the methodological boundaries that have hitherto defined research in the basic sciences, as well as clinical and epidemiological research. Instead, they have embraced a multidisciplinary approach along with the diversity of methods that it brings.

## IV. THE USE OF HEALTH SYSTEMS AND POLICY ANALYSIS BY POLICY MAKERS

The **Ministerial Summit on Health Research** held in Mexico City in 2004 focused attention on the "know-do gap" and the need for knowledge translation to bridge the gap. Many scholars have since written about the nature of this gap, the factors contributing to it, and strategies for addressing it. The gap, as articulated by **Omaswa and Boufford (2010)**, is between "knowing what can make a difference in the health of individuals and populations, and taking action to achieve results." It can be thought of as consisting of two parts or being of two types: first, the knowledge translation gap, which refers to research evidence not being used for policy-making, and second, the implementation gap, which refers to policies that have been adopted and exist on the books not being implemented on the ground.

The former–the evidence to policy gap–is the focus of this study. It is of concern to both researchers and policy-makers. In the African context, the 52$^{nd}$ Health Ministers Conference of the East, Central, and Southern African Health Community in October 2010 emphasized the persisting gap between knowledge and policy-making. The ministers recognized the limited production and use of locally generated evidence in policy making within the region (**EQUINET et al 2010**).

Lavis et al (2006) posits four models for linking knowledge to policy change: (1) producer push model, (2) user pull model, (3) exchange model, and (4) the integrated model. The first model is premised on researchers being the primary actors, who catalyze policy changes by disseminating research findings. Hence, questions about how best to package research findings in policy briefs, research syntheses etc. and draw out concrete policy recommendations follow closely from this model.

The user pull model describes scenarios where policy-makers and managers are the main actors attempting to link knowledge with practice. For example, in a study on building the capacity of ministries and ministers of health, Omaswa and Boufford (2010) report that there was a strong demand from ministers for "situation analysis" of the country context that explain the macroeconomic context, public expectations, tools and levers that ministers have to change the system. Donors routinely invest in baseline studies and health systems assessments that allow them to make strategic decisions about where to invest their funds. These are both examples of users demanding information to guide their decision-making.

The exchange model refers to situations where policy-makers and researchers form partnerships to investigate questions of common interest. This partnership emerges when their interests are aligned, and could happen any time in the policy process. The final model of integration refers to the setting up of formal knowledge translation platforms, which could be national or regional entities that institutionalize push, pull and exchange elements.

Most empirical studies into knowledge translation have focused on the push and pull models, or the supply and demand for research. Based on a study of conceptual frameworks and empirical evidence for the push approach, **Lavis (2003)** offers several recommendations to researchers attempting to inject evidence into the policy process: transfer actionable messages based on bodies of research, not the whole body of research; fine-tune message and approach according to the audience; identify and work with the most credible messenger for each target audience; and use interactive methods.

Through interviews with both policy-makers and researchers, **Campbell et al (2009)** found that policy makers reported using research to inform policy content, but rarely used it to set policy agendas or evaluate the impact of policy. The policy makers also reported difficulty in accessing useful research syntheses. For their part, only a third of researchers reported developing targeted strategies to inform policy-makers of their findings. There was demand on both sides for greater exchange and dialogue. The authors concluded with the following recommendations to increase use of evidence in health policy: make research findings more accessible to policy makers, increase opportunities for interaction between policy makers and researchers, address the lack of incentives for academics to link with policy, and increase the relevance of research to policy.

**Credibility and reliability:** evidence must come from trusted sources to eliminate need for the decision-maker to appraise and assess the evidence. This can be established through: authors' names, peer recommendations, source of research, familiarity of logos.

**Quality:** evidence must be current, jargon-free, and transparent; must include what worked and what did not; and must have recommendations ranked in order of effectiveness.

**Cost:** discussion must include a cost analysis.

**Context:** evidence must be presented within local/national/regional/global context.

**Timing:** evidence appears on issues they are already working on.

**Connections:** where can they get more information.

**Customization:** presented evidence must be flexible as it is often used for: cutting and pasting for presentations; passing on to colleagues; printing for their own use; saving and filing; composing a briefing note.

**Modes of delivery:** electronic format preferred but hard copy also desired.

Source: **The Knowledge Translation Toolkit**

In a systematic review of studies that focused on health policy-makers' perception of the use of research evidence in health policy making, **Innvaer et al (2002)** found that the most commonly reported facilitators for evidence use were: personal contact, timely relevance of research, inclusion of summaries with clear policy recommendations. In addition to the absence of these facilitators, mutual mistrust that often stemmed from researchers lacking an understanding for politics and policy-making having an insufficient appreciation for science was a common barrier for greater policy application of evidence. The table above summarizes some of the elements that policy-makers look for when accessing research (**Bennett and Jessani 2011**).

Many of the factors contributing to the knowledge to policy gap discussed above were echoed in our interviews with policy-makers and researchers for this study. The following were highlighted by several key informants as reasons for the under-usage of HSPR in policy-making:

- Awareness about the value of evidence and the demand for research among policy-makers remains low
- Even if there is demand, academic research is hard to access when it is not in the public domain
- Policy-makers have insufficient time to read and synthesize large bodies of literature
- Policy-makers do not trust research findings when the institutions and people involved are unknown to them
- Research is often driven by donors rather than local stakeholders; hence the findings are not of high relevance to ongoing policy-related discussions

## V. EXISTING HEALTH SYSTEMS AND POLICY ANALYSIS RESOURCES IN AFRICA

### THE STATUS OF HPSR INSTITUTIONS

As the field of HPSR has grown in the past decade, several studies examining the volume and nature of HPSR as well as the status of HPSR institutions in low and middle income countries (LMICs) have emerged. While there is no assessment that looks exclusively at the state of HPSR in Africa, Gilson and Raphaely **(2008)** undertook a review of published literature undertaking health policy analysis in LMICs between 1994 and 2007. Of the 391 published articles in peer-reviewed journals that met the selection criteria for the study, 44% focused on Africa. However, very few countries had more than 5 articles focused on them. Additionally, most of the articles examined issues in a single country, while multi-country policy analyses were done infrequently. About two thirds of the publications were authored by people not working in an organization located in a LMIC. The authors concluded from this finding that greater health policy analysis capacity is needed in LMICs.

A more recent study of the state of health policy and systems research in LMIC by **Adam et al (2011)** supports these findings. They undertook biblio-metric analysis to assess the increase in HPSR between 2003 and 2009, and analyzed results from a 2010 survey of 96 research institutions to gauge the capacity and funding for HPSR. While the volume of HPSR publications focused on LMIC has grown, only 4% of them had authors from low income countries (LICs) as leads. The institutional survey similarly suggests that despite progress in terms of improved infrastructure and funding for HPSR research globally, overall capacity in LICs remains poor.

Reviewing the state of HPSR, **Bennett et al (2011)** comment that there is still heavy reliance on external funding. The authors argue that external funders tend to support studies on intervention scale-up, and less on complex systems issues. Given their bias towards traditional health research, they opt for studies that investigate discrete technical questions that are easier to subject to hypothesis testing while underfunding analyses of complex policy issues. Greater local ownership and investment is needed to ensure that health systems and policy research focuses on questions of greatest relevance to LMICs.

With funding from the Rockefeller Foundation, the Alliance for Health Policy and Systems Research undertook a global landscaping of health policy analysis institutes (HPAI) in LMICs (**Bennett et al. 2012**). HPAI are defined as institutions that support health policy development and implementation through analysis and research. They serve some of the following functions:

- Conduct policy-relevant research and analysis
- Provide policy advice and technical assistance for policy formulation and evaluation
- Conduct policy dialogues at national- and international-levels
- Knowledge building and capacity development for policy-makers

The study found that the number of HPAI in low and middle income countries is growing. Most of them are undertaking the first two functions from the list above, while the latter two functions are undersupplied. In other words, they have made more progress in terms of producing research products as well as providing technical advice to policy-makers, but remain weak in terms of hosting policy dialogues with diverse stakeholders and building awareness about latest health systems evidence and thinking about policy-makers.

As part of the current scoping exercise focused on Africa, we used desk reviews and internet searches to identify HPAI across Africa. We contacted 27 institutions in 10 countries, and received responses from 14 institutions (a full list is provided in annex A). In both the initial list of 26 as well as the list of 14 that responded to our requests for an interview, the institutions clustered in a handful of African countries: South Africa, Uganda, Kenya, Tanzania, Ghana, and Nigeria (these were the countries where we could find more than 1 HPAI through our search methodology of desk reviews and internet searches). The list of institutions we spoke with includes research units or institutions based at universities, as well as independent research institutions and think-tanks. We interviewed, either in person or by phone, focal persons at all 14 organizations that responded to our request for an interview. We also administered a brief self-reported questionnaire, which was filled out by 12 of the 14 organizations.

Some of the common themes emerging from the interviews are summarized below, while the table presents key indicators from the self-administered survey:

- Most of the HPAI interviewed are engaged in some health system research. However, very few are engaged in analysis across all 6 of the WHO health systems building blocks. Of the 6 areas, medical technologies and supply chain management is the least studied topic.
- There is growing pressure from donors to show how research has an impact. But this has proven difficult to achieve. All institutions reported producing diverse disseminations products including health policy briefs, in-house reports, and journal publications in the survey. However, in the interviews they all discussed the challenges they face in successfully disseminating findings from analytical work to diverse policy audiences. The researchers often lacked the time, skills or incentives to develop policy briefs targeting non-technical audiences. Staff handling communications, in institutions where such persons exist, often do not understand the content of research. Many key informants reported that getting the attention of the media has proven difficult. In part this is a function of research institutions not having staff with public relations skills. Researchers do not have the interest to pursue innovative dissemination strategies.
- While analysts from the HPAI report frequent engagement with policy-makers in government through participation in expert groups as well as informal links, a minority of them engage in any way with the private sector or civil society groups.
- Many of the institutions interviewed reported facing significant research capacity constraints.
- Analysts who were engaged in cross-country analysis within Africa mentioned that consistent and comparable health systems data was not readily available
- In the absence of domestic or regional funding for research, these institutions reported relying on external/donor funding. They felt that at times the focus of their research was driven by the demands and priorities of donors, rather than local needs.

| **Indicator** | **Number of Institutions** |
|---|---|
| *Conducting health systems research and policy analysis* | 12/12 |
| *Produce analysis across all health system domains* | 0/12 |

| | |
|---|---|
| *Informing the policy process at national level* | 12/12 |
| *Publish policy briefs* | 11/12 |
| *Knowledge building and capacity development for policy makers* | 8/12 |
| *Undertake research and analysis requested by government* | 10/12 |
| *Direct engagement with the private sector and civil society* | 6/12 |

Source: Institutional surveys

## REGIONAL NETWORKS AND INTERGOVERNMENTAL BODIES

There are numerous health-related networks and partnerships in Africa. While undertaking an exhaustive study of all of them was beyond the scope of this exercise, we undertook a desk review of 10 existing networks active in Africa. Additionally, we contacted the convenors of a subset of networks whose focus seemed to be closely related to the goals of this landscaping exercise. They were: (1) the African Health Observatory hosted by WHO AFRO to consolidate health and health systems data for member countries in Africa, (2) the African Health Economics Association (AfHEA) which aims to promote the use of appropriate health economics tools to generate high quality evidence in the areas of health economics and financing in Africa, (3) the African Health System Governance Network (ASHGovNET) which is working with African institutions that can be leveraged to strengthen ministerial capacity to serve as effective stewards of the health system, (4) the Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA) that is focused on developing capacity for producing health systems research and policy analysis, and (5) the Regional Network on Equity in Health in Southern Africa (EQUINET) which is focused on generating evidence on equity and social justice in health in its sub-region (for more information about the list of networks included in the desk review as well as the five interviewed, please refer to Annex B). We interviewed the convenors in get their feedback on what the critical gaps are in terms of the production and use of HPSR in Africa.

Based on desk review of African networks, interviews with those convenors of the five networks mentioned above, and feedback from key informants interviewed for this study about various African networks, we drew several conclusions about the state of HPSR-related networks in Africa. First, many of the existing networks focus on specialized aspects of health systems and policy analysis, or adopt a specific lens like health equity or health economics to study health systems issues. This allows them to undertake deep analysis on specific topics, developing a comparative advantage and expertise in their chosen area of work. Second, most of them have a sub-regional focus and do not cover the full continent. Some like CHEPSAA bring together academic institutions from a subset of African countries, typically those with well-established schools of public health. Others like EQUINET and the African Health Observatory by design focus on a sub-region within Africa. There are very few networks that are pan-African by design like AfHEA. Third, there is lack of clarity amongst these actors as well as the general community about what the other does. Consequently, the idea of networking the networks or creating a portal that provides information about and links to each resonated widely.

In addition to these networks and initiatives, there are regional and sub-regional intergovernmental bodies that have the mandate and power to convene top leaders from their member countries. The African Union supported by NEPAD is the only pan-African body which routinely convenes ministers of health to talk about health priorities. Others like ECSA and WAHO convene health officials within their sub-regions. These

gatherings offer an opportunity for cross-country learning and policy diffusion. Closer linkage between the intergovernmental bodies with the political mandate to host policy dialogue and the research community that has deep knowledge of health systems issues would be ideal.

## VI. BUILDING A HEALTH POLICY ENGAGEMENT NETWORK IN AFRICA

### THE NEED

Drawing on the review of the literature as well as feedback received from various stakeholders, we can now articulate the critical HPSR gaps that remain despite the progress that has been made. While the generation of HPSR focused on Africa and by African institutions keeps improving, its integration into the policy process remains weak at best. Several factors contribute to the poor linkage between evidence production and its policy application.

- Generating original health systems research, which uses standard methods that emphasize the deductive approach of hypothesis testing and produce results that are publishable in peer-reviewed journals, remains the dominant mode for most health systems and policy analysts. In contrast, applied analytical products that summarize existing bodies of knowledge to distill key insights that are applicable to the policy process, or use secondary data sources to investigate a policy question with a quick turnaround time, or provide systematic reviews of systems or policy interventions have received less attention. The latter types of products are critical for making evidence from health systems research readily accessible to policy-makers and other health sector stakeholders, and both catalyze and contribute to policy debates.
- Researchers may require additional training to learn how to disseminate research findings to diverse audiences using innovative methods, as well as to engage with the media. Other "knowledge brokers" like communications officers may be required to assist with knowledge translation.
- There is low demand for evidence from policy-makers. They do not have ready access or the time to access academic studies. Established norms for evidence-based policy making is lacking in many African countries. Additionally, the lack of trust between policy-makers and researchers can be an obstacle.
- Health policy analysis institutions, both academic institutions and independent think tanks, are concentrated in a few African countries with relatively high capacity. These institutions are at the forefront of producing health policy analyses, and participate actively in some of the aforementioned networks. There are however several countries in Africa that are lacking national health policy and systems analysis institutions.
- While existing networks and initiatives are producing a wealth of HPSR as well as investing in developing research capacity, building a community of practice around effective policy engagement through applied research and widespread dissemination, as well as building demand from policy-makers for health systems information is not part of the core mission of any of the existing initiatives.
- There is at present no pan-African mechanism to synthesize HPSR to articulate the policy priorities of the continent, or ensure that African countries are all moving forward and learning from collective know-how and experience. Intergovernmental and continental bodies are meeting to debate and discuss critical health systems issues, but there is no formal mechanism for HPSR to feed into these high-level discussions about the health policy priorities of the continent.
- While there are regional observatories that store cross-country data on health system performance, there is no single central repository for HPSR about Africa that is generated by institutions and network from across the entire continent. In the absence of such repository, analytical outputs from these institutions and networks are not easily and freely available. They are not being used to their maximum potential, and nor are they archived for sustained use. Additionally, select knowledge that is generated by donor-funded projects is often lost once the projects end.

## THE PROPOSED NETWORK

Based on the feedback received, we propose the creation an African Health Policy Engagement Network (HPEN). The overarching goal of the African HPEN would be to support and promote evidence-based health policy-making in Africa by bridging the gap between the academic research community and policy-makers. The Network will link existing African HPAI, networks, and regional bodies in order to serve the following functions:

- **Undertake applied HPSR:** The African HPEN will work through its member institutions to produce analyses that comprehensively describe, analyse and assess health systems and the changes they undergo. To the extent there is need to build analytical capacity, the African HPEN will leverage existing initiatives like CHEPSAA and AfHEA that are focused on research methods for HPSR. We envision the proposed network focusing on HPSR with the following characteristics:
    - Focuses on health systems issues of immediate policy relevance to national and regional stakeholders in Africa
    - Is *applied* by which we mean it typically uses existing data in order to produce results in real time or it synthesizes and summarizes existing research
    - Investigates health policy as it pertains to health systems issues (as opposed to policies regarding clinical interventions)
    - Is written with a non-technical audience in mind using formats such as short policy briefs (as opposed to journal articles that target other scholars)
    - Provides clear recommendations for policy makers and health sector stakeholders
- **Strategic dissemination to influence national policy development:** The African HPEN will promote active engagement with policy-makers at the national-level by building the knowledge translation capacity of analysts and setting up a community of practice for member institutions around policy engagement. The focus will be on disseminating information and research findings using methods and products tailored for different audiences, engaging with the media, and hosting national and international policy dialogues.
- **Strategic engagement to facilitate cross-country dialogue and stimulate demand for HPSR:** The African HPEN will work closely with regional and sub-regional intergovernmental bodies that have the mandate to convene high-level policy-makers and facilitate cross-country dialogue on health policy issues. The Network will contribute to cross-country discussions on health policy issues by becoming the conduit for aggregating, synthesizing, and organizing evidence on health systems and channelling technical expertise from across the continent that will feed high-level discussions on health systems issues. It will also foster an ethos of evidence-based policy-making, increasing awareness about the utility of research and stimulating demand for HPSR among policy makers.
- **Serve as a repository for HPSR:** The African HPEN will serve as a clearinghouse for HPSR it produces as well as that produced by selected other institutions, regional and thematic networks, and health projects. As such, it will serve as a "one-stop-shop" for analysis on health systems and policy issues from across the continent, as well as information about what various institutions, networks and initiatives engages in HPSR are doing.

Its core principles would be:

- The Network will have a *pan-African* focus.
- It will be *owned and operated* by African institutions. Specifically, it will have a steering body consisting of stakeholders in the region and it will link *existing* African institutions engaged in HPSR.
- The Network will support and build from the work of existing institutions and networks, and avoid duplication.
- The Network will adopt a broad and comprehensive view of health systems development, covering the broad array of health system building blocks, such as financing, health workforce, technologies,

information, and leadership and governance, as well as primary health care, the effect of other social determinants on health service delivery and inter-sectorial action for health.

The overarching goal, the key functions, and principles guiding the Network are to be discussed in detail at the Bellagio Consultation. Once there is consensus on these issues, the group will also discuss and agree on the key activities that the Network will undertake in each functional domain as well as the governance and operating structure for the network. With that in mind, we have listed below some of the key questions that will be discussed in Bellagio.

## VII. KEY QUESTIONS FOR DISCUSSION IN BELLAGIO

- Do we all agree that bridging the divide between the HPSR community and the policy community is a critical need?
- Would a network of existing African institutions focused on promoting health policy engagement be the right way to address this gap?
- Which of the following seem like useful functions for the network to address? Are there others we should add to the list?
    - Promote health systems and health policy analysis of the following kind
        - Applied research on contemporary health systems issues and health policy analysis in African countries
        - Systematic reviews and research syntheses on health systems and policy issues
        - Position papers for global health diplomacy
    - Host training programs to build policy engagement skills among researchers on topics such as:
        - Writing policy briefs and position papers
        - Developing diverse dissemination products
        - Implementing a successful media campaign
        - Hosting policy dialogues
    - Partner with regional intergovernmental bodies to
        - Develop and deliver short courses on health systems and policy issues targeting policy-makers and health system managers
        - Host high-level policy dialogues on technical issues
    - Serve as a clearing house for HPSR
        - Developing a repository of applied health systems research and policy analysis
        - Serve as a portal to existing institutions, initiatives and networks
- Do all the aforementioned functions seem valuable? Are there other functions you would add to the list? What are functions you would remove because they are being served by others or are not important?
- As per the current proposal, the African HPEN would focus on developing policy engagement capacity but not research capacity. This is in part because there are other networks and initiatives such as CHEPSAA and numerous others that are focused on developing research capacity. Does that seem appropriate? How can HPEN formally engage with and leverage the work of existing networks?
- What would a policy-maker want to get from a network such as this? Would they be comfortable using such a network if it were hosted in another country?
- What is the ideal structure for such a network?
- What are the next steps in setting up such a network?
- What are some challenges you foresee in setting up such a network?

## ANNEX 1

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## ANNEX 2

### HEALTH SYSTEMS AND POLICY ANALYSIS INSTITUTIONS

The table below lists the institutions contacted for this study. The bottom half in grey are the institutions that did not respond to our request for an interview.

| Institution | Country | City | Type |
|---|---|---|---|
| Health Policy Research Group, College of Medicine, Univ of Nigeria, Enugu | Nigeria | Enugu | Univ |
| Institute for Statistical Social and Economic Research, University of Ghana | Ghana | Accra | Univ |
| Noguchi Memorial Institute for Medical Research | Ghana | Legon | Univ |
| Center for Health and Social Services (CHeSS) | Ghana | Accra | NGO |
| African Population and Health Research Centre (APHRC) | Kenya | Nairobi | NGO |
| KEMRI Wellcome Trust | Kenya | Mombasa | Govt |
| Makerere School of Public Health | Uganda | Kampala | Univ |
| African Center for Global Health and Social Transformation | Uganda | Kampala | NGO |
| East, Central and Southern African Health Community | Tanzania | Arusha | NGO |
| Health Economics Unit, University of Cape Town | SA | Cape Town | Univ |
| Centre for Health Policy (CHP), University of Witwatersrand | SA | Joburg | Univ |
| Centre for Health Systems Research and Development (CHSR&D), University of Free State | SA | Bloemfontein | Univ |
| CESAG | Senegal | Dakar | Univ |
| Social Research Center, American University Cairo | Egypt | Cairo | Univ |
| Health Policy Training and Research Programme | Nigeria | Ibadan | Univ |
| Health Research Unit | Ghana | Accra | Govt |
| Ethiopian Health and Nutrition Research Institute | Ethiopia | Addis | Govt |
| Kenya Institute for Public Policy Research and Analysis (KIPPRA) | Kenya | Nairobi | NGO |
| African Medical Research Foundation (AMREF) | Kenya | Nairobi | NGO |
| Muhimbili Univ of Health | Tanzania | Dar | Univ |
| Ifkara Health Institute | Tanzania | Dar | NGO |
| Health Systems Trust (HST) | SA | Durban | NGO |
| Manhiça Centre for Health Research (CISM) | Mozambique | Maputo | Gov |
| Beira Operations Research Centre (BORC) | Mozambique | Beira | Gov |
| Centre de formation et de recherche en Santé de la Reproduction (CEFOREP) | Senegal | Dakar | NGO |
| Institut de Santé et Développement (ISED) | Senegal | Dakar | Univ |
| Higher Institute of Health Management (ISMS) | Senegal | | Gov |

## ANNEX 3

### HSPR NETWORKS IN AFRICA

We studied the following networks as part of the desk review:

1 The African Health Observatory (AHO)

2 African Health Economics Association (AfHEA)

3 African Health Systems Governance Network (ASHGovNET)

4 Resilient and Responsive Health Systems (RESYST)

5 The Consortium for Health Policy & Systems Analysis in Africa (CHEPSAA)

6 The Regional Network on Equity in Health in Southern Africa (EQUINET)

7 Evidence Informed Policy Network (EVIPNet)

8 Supporting the Use of Research Evidence (SURE)

9 The Region of East Africa Community Health Policy Initiative (REACH PI)

10 Maghreb Economics and Health System Network (RESSMA)

Of these 10, we studied the following five more closely, including interviewing their convenors for feedback on the achievements of existing networks in Africa and perceived gaps. Below, we have briefly described the five networks based on information on their websites as well as background documents shared with us.

#### The African Health Observatory

The African Health Observatory (AHO) is platform hosted by WHO AFRO that facilitates the acquisition, generation, diffusion, translation and use of information, evidence and knowledge (IEK) by countries to improve national health systems and outcomes. It includes:

- a data-statistics platform enabling data download, processing and analysis, or access to ready-made statistics;
- a Wiki-based collaborative space for the production and updating of comprehensive and analytical Regional and country profiles based on both quantitative and qualitative information;
- a repository of key publications from or associated with the Observatory;
- the African Health Monitor a quarterly periodical;
- a platform providing relevant tools that enable networking, collaborative work and learning within and between groups, communities of practice, institutions, and national health observatories.

#### African Health Economics Association (AfHEA)

AfHEA is an association of African experts and students in health economics, financing, policy, and related fields whose mission is to promote and strengthen the use of health economics and health policy analysis. Its specific objectives are to serve as forum for information sharing among individuals working in health economics and related disciplines in Africa; foster the development and retention of health economics capacity in Africa; promote the production and dissemination of research by health economists and policy analysts in Africa; promote the appropriate use of health economics and policy analysis tools in decision-making; support health policy development and advise policy makers on equitable and viable health care financing options; and represent the interests of African health economists and policy analysts in international fora. One of its core activities has been to organize a bi-annual conference that features latest research on health economics and policy issues. It has also worked to promote the use of this information in policy-making, for example by attending the African Union's Ministers of Health Conference in 2009 and providing inputs into the development of a health financing strategy by the African Union.

### African Health Systems Governance Network (ASHGovNET)

ASHGovNET is a network of African institutions that have agreed to serve as a resource to support the work of ministries of health at the country-level and advocate for effective governance of the health system. It was created in 2009 as part of the recommendations of a study *"Strong Ministries for Strong Health Systems"* (Omaswa and Boufford, 2009). The African Center for Global Health and Social Transformation (ACHEST) based in Kampala, Uganda serves as the secretariat for the network. The network members participate in a very active e-discussion forum hosted by ACHEST, which also contributes to a number of high-level discussions in Africa on a range of health systems topics. The network has conducted mapping studies to identify health resource partner institutions (HRPIs) in five African countries. Once finalized, the mapping tool will be used to identify HRPIs in other countries as well.

### The Consortium for Health Policy & Systems Analysis in Africa (CHEPSAA)

CHEPSAA is network of 7 universities in Africa and 4 universities from Europe that aims to build the field of health policy and systems analysis through:

- Assessing the capacity development needs of the African members and national policy networks.
- Supporting the development of African researchers and educators.
- Strengthening the development of HPSA courses.
- Strengthening networking among the health policy and systems education, research and policy communities and strengthening the process of getting research into policy and practice.
- Project management and knowledge management.

It is led by the Health Economics Unit (HEU) at the University of Cape Town in Cape Town, South Africa.

### The Regional Network on Equity in Health in Southern Africa (EQUINET)

EQUINET is a network of professionals, civil society members, policy makers, state officials and others within the region and serves as an "equity catalyst" to promote and realize shared values of equity and social justice in health. The EQUINET secretariat is located at the Training and Research Support Centre in Harare. It publishes policy briefs, discussion papers, and country reports, and facilitates high-level meetings on a range of issues related to health equity. In partnership with the East, Central, and Southern African Health Community (ECSA) and national stakeholders, it compiles the *Equity Watch* country reports that track and report on evidence on health equity and progress in addressing inequalities in health as per a resolution enacted by the ECSA Regional Health Ministers in 2010.