A decade of health systems research

Lessons learnt in the WHO/DGIS/HSR and recasting the strategies for research capacity strengthening in Africa

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EXECUTIVE SUMMARY

Since 1987, the Joint WHO/DGIS HSR Project has been working with Eastern and Southern African countries on the establishment and/or strengthening of national health systems research (HSR). Following a decade of implementation, it has contributed to the demystification of research so that HSR has become an acceptable tool for generating evidence-based information for policy and program decisions. It promoted the development of research culture and the training of a cadre of health workers; facilitated the establishment of HSR structures and mechanisms within the health sector; provided a forum for networking; the exchange of experience and technical cooperation (TCDC) in HSR among these countries. It institutionalized a methodology for HSR training and the training of trainers utilizing a HSR training series developed for this purpose. It promoted the conduct of HSR studies as well as the application of research evidence at different levels.

Evaluation of the HSR project showed that most studies have focused on operational issues and have had less impact on health policies than expected; there is limited networking among researchers in countries and limited application of skills among those who had been trained in HSR. Lessons learnt include the need to strengthen networking and participatory and team planning of HSR priorities, HSR agenda and policy-oriented research. Partnership among policy makers, program managers and researchers in planning and implementing HSR has not been the norm while financial support in countries to the HSR process needed to be improved and sustained.

At the start of its second decade of implementation, a new approach in HSR capacity strengthening took stock of these lessons. The HSR project objectives remain valid, but the strategies called for recasting taking into consideration the readiness of participating countries. This approach focuses on strengthening internal and inter-country networking and partnership among researchers and policy-makers/program managers in prioritizing HSR issues on key program areas of regional importance, in formulating HSR frameworks on the top HSR priorities and promoting the use of evidence for policy and program decisions. It entails bringing together teams from selected countries that are in the forefront in the key health problem area under consideration. This has been applied in two inter-country consultations organized by the WHO/AFRO/HSR: the first on health sector reform, the second on responsiveness of the health systems to HIV/AIDS.

Lessons learnt from the first consultation were considered in organizing the second consultation. The newly-launched WHO conceptual framework on health systems performance provided a basis for identifying gaps in HIV/AIDS interventions and organizing the potential areas for HSR according to the four functions of the health system. The 13 countries that participated are among those with the highest rate of HIV/AIDS globally. They have expressed a desire to participate in the multi-country studies involving five HSR frameworks developed at the consultation. The external partners expressed interest in participating in the follow-up with possibility of funding. The WHO/AFRO/HSR has put together a pro-active regional package and has initiated concrete steps to provide follow-up support to the national teams in implementing the outcomes. It is notable that in a third of the countries that participated in the HIV/AIDS consultation, concrete steps had been taken to start the implementation of their POAs with feed-back provided to the WHO/AFRO/HSR Program.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AFRO</td>
<td>African Regional Office</td>
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<td>CRHS</td>
<td>Commonwealth Regional Health Secretariat</td>
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<td>DGIS</td>
<td>Dutch Ministry of Cooperation</td>
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<td>ECSACON</td>
<td>Eastern and Southern African Conference on Nursing</td>
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<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<td>GTZ</td>
<td>German Technical Cooperation</td>
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<td>HIV/AIDS</td>
<td>Human Immune-deficiency Virus/ Acquired Immune-deficiency Syndrome</td>
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<td>HSR</td>
<td>Health Systems Research</td>
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<td>KIT</td>
<td>Royal Tropical Institute (Amsterdam)</td>
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<td>NACP</td>
<td>National AIDS Control Program</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>POA</td>
<td>Plan of Action</td>
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<td>RCS</td>
<td>Research Capacity Strengthening</td>
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<td>SOMANET</td>
<td>Social Science Medicine Network</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TCDC</td>
<td>Technical Cooperation among Developing Countries</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>UNAIDS</td>
<td>United Nations AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHR</td>
<td>World Health Report</td>
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BACKGROUND


A brief presentation on the project objectives, strategies and activities is followed by a summary of its achievements and limitations resulting from the first decade of implementation. The start of its second decade witnessed the recasting of project strategies in line with the changing need to build on the established national HSR capacities and to ensure program sustainability.

The WHO/DGIS/HSR Project

Initiation of the HSR Project: Phase 1

Concerned over the state of primary health care implementation in Africa, the WHO, DGIS and KIT decided in 1985 to pool their resources and initiate a joint HSR Project. The Southern African sub-region was considered to be the most appropriate starting place where some countries had initiated related research activities. A consultation meeting was held in 1986 with representatives of these countries (Botswana, Malawi, Mauritius, Tanzania and Zimbabwe) who expressed their interest in participating in the project. In March 1987 the project formally started with its staff based at the WHO/AFRO Sub-regional Office in Harare. By the end of Phase 1 (1987 – 1991) the participating countries had doubled. The first inter-country meeting among these countries (1987) identified three main areas for concentrated effort in their action plans:

- Strengthening of local structures to promote HSR
- Strengthening of local capabilities to conduct HSR
- Enhancing internal and inter-country communication with respect to HSR

HSR Project Objectives, Strategies and Activities

HSR aims to bridge the gap between research efforts and research needs through a participatory and interdisciplinary approach, involving health managers as well as health care providers and users in the process of problem identification and analysis.

Its overall objective is to contribute to the generation of evidence-based information for use by policy makers and health managers at all levels of the health system towards the strengthening of health systems and services in countries of the region.2

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1 DGIS – Dutch Ministry of Cooperation. KIT – Royal Tropical Institute (Amsterdam)
The specific objectives are:

1) Strengthening of national HSR structures and mechanisms
2) Capacity-building among health and related staff; researchers to develop and implement HSR
3) Technical and financial support to the development and implementation of HSR proposals
4) Promoting utilization of HSR results at all decision-making levels
5) Facilitating mutual exchange of experience in HSR and technical cooperation among developing countries (TCDC).

The key strategies and activities are:

1) Advocacy to create awareness and consensus-building on the value and uses of HSR through national consultative meetings involving stakeholders in health research, policies and programs.
2) Capacity building through HSR training, training of trainers and the integration of research in selected curricula; development of HSR training materials.
3) Technical and financial support to the conduct of research and promote the use of results
4) Strengthening of HSR institutions (focal points, and/or HSR Units) through the establishment of HSR Units and appointment of HSR Focal Points (HSR/FPs); sharing experiences and joint planning; TCDC.
5) Networking through inter-country meetings, publications, linkages with institutional and international agencies and other donors.

Phases 2 and 3 of the HSR Project

During Phase 2 of the HSR Project: (1992 – 1995), one of the important decisions made by the participating countries was to shift the responsibility for its execution starting with Phase 3, from WHO/HQ to WHO/AFRO and to gradually decrease dependence on the principal donor by mobilizing multi-donor support. The participating countries increased to 18 by the end of this phase.

During Phase 3 (1996 – 2000), Project management became the responsibility of WHO/AFRO. In 1998 the 38th Regional Committee recommended that the HSR Project be adopted as a regional program, thus expanding its coverage to all member states. AFRO starting with the-1998 – 1999 biennium established a regular budget line.

HSR Approach/Process

The approach to project implementation has been flexible and pragmatic in response to country needs, with emphasis on:

✶ Institutional development to ensure the sustainability of HSR
✶ Development of HSR skills to strengthen national capacities in this area
Research to improve the basis for informed decision-making in health at all levels, starting from the community up to the national level.

The HSR approach follows a process that is linked with support activities by the HSR Project (see Figure 1). The sequence of activities depends on the stage of development of HSR in the respective countries and their priorities as well as socio-economic realities.

Table 1 summarizes the achievements of the HSR project at regional and country levels.

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Figure 1: HSR Process/Approach

HEALTH SYSTEMS RESEARCH PROCESS

Advocacy:
- Awareness/consensus building
- Needs identification

Research Agenda setting and prioritizing

INSTITUTIONAL HEALTH SYSTEMS RESEARCH CAPACITY STRENGTHENING

Skills development:
- HSR methodology
- Trainers

HSR studies:
- Planning
- Implementation
- Application

Networking:
- TCDC
- Collaboration

Strengthening HSR structures and mechanisms
## Table 1: Results/impact of the HSR Project at Regional and Country Levels

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>REGIONAL LEVEL RESULTS</th>
<th>COUNTRY LEVEL RESULTS</th>
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<tr>
<td><strong>To strengthen national institutional capacity on HSR</strong></td>
<td>♦ Motivated MoHs to establish HSR Units and budget lines for HSR; appoint HSR Focal Points. ♦ High level representation of MoHs in Technical Advisory Committee &amp; Steering Committee meetings of HSR Project ♦ Expansion of HSR Project into the HSR Regional Program of WHO/AFRO ♦ Increasing demand for HSR training beyond MoHs and outside ESA countries for HSR support</td>
<td>♦ 14 of 18 ESA countries have established HSR Unit or Focal Point in the MoH. ♦ HSR Annual Plans have been established; 6 have developed long term plans; ♦ Regular budget line exists in 15; some with additional external funding. ♦ HSR policies either developed (BOT, ZAM, ZIM) or under development (MOZ, NAM). ♦ HSR Focal Points established in 3 medical schools (TAN, ZAM, ZIM); published inventories of University-based HSR and related studies. ♦ Decentralization of HSR on-going in BOT, ZIM, ZAM, TAN. ♦ Demand for HSR has spread beyond the MoH to NGOs, training institutions (Medical, Nursing, Public Health Schools); other government sectors.</td>
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<td><strong>To build national capacity on HSR methodology</strong></td>
<td>♦ 1790 provincial and district health workers trained on HSR; 300 of these as Trainers through inter-country training. ♦ 6 HSR training modules have been developed and widely disseminated; translated into French and Portuguese by WHO and into other languages by other institutions. ♦ “Global adoption” of HSR series especially Volume 2 on proposal development and report writing. ♦ HSR integrated in selected curricular in 3 universities (TAN, ZAM, ZIM).</td>
<td>♦ Countries are organizing HSR training using their funds &amp; local trainers. ♦ Some Universities incorporated HSR into selected curricula (MOZ, TAN, ZAM, ZIM). HSR Focal Points have been created at the last 3 Universities and in three NGOs. The HSR-trained critical mass in these Universities is not only teaching HSR methodology; they are being contracted by government and other agencies to carry out policy-related HSR studies. ♦ The trained critical mass in some countries has become a resource pool that MoHs and other sectors commissions to conduct research (e.g. in Lesotho, Mozambique).</td>
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<td><strong>To support the development and implementation</strong></td>
<td>♦ 163 HSR proposals supported as part of the training on HSR organized by the HSR project.</td>
<td>♦ Topics that had been researched from 1987 to 1999: MCH/FP &amp; Nutrition (22%); Disease Control (19%); PHC – water &amp; sanitation (13%); AIDS/STD (17%); Management (32%), quality of services &amp; policy-linked research (7%). ♦ External evaluation assess quality of research carried out to be good,</td>
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<td>OBJECTIVES</td>
<td>REGIONAL LEVEL RESULTS</td>
<td>COUNTRY LEVEL RESULTS</td>
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<td>on of HSR studies</td>
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<td>♦ Some HSR studies conducted by nationals have been published either in the form of books or in international journals.</td>
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<td>To promote utilization of HSR results in decision-making.</td>
<td>♦ 44% of research results fully implemented; 20% partially Supported Annual Research Days in countries</td>
<td>♦ Operational level staff as the main target for HSR training selected their studies. Findings have had an effect on changing operational guidelines &amp; health programs6.</td>
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<td>♦ Inter-country sharing of experience and joint planning among national HSR/FPs; provided technical inputs.</td>
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<td>♦ Efficient collaboration with other HSR regional initiatives.</td>
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<td>♦ Publications7: 8; 2 volumes of Summaries of HSR Studies; 1 Directory of Critical Mass in the Region; Newsletter (2x/year)</td>
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<td>To facilitate exchange of experience on HSR, networking and TCDC</td>
<td>♦ HSR trainers assist as Facilitators/Trainers in various countries of the Region as part of TCDC.</td>
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<td></td>
<td>♦ Inter-country sharing of experience and joint planning among national HSR/FPs; provided technical inputs.</td>
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<td>♦ Efficient collaboration with other HSR regional initiatives.</td>
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5 Neufeld, V. et. al. 1994.
Limitations of the HSR Project: First Decade of Implementation

Institutional Strengthening

Institutionalization of HSR in a number of countries has been affected by:

- Inadequate resource allocation to HSR both financially and in manpower availability.
- Human resource issues: staff transfer, brain drain, lack of career structure.

A high turnover of national health authorities has resulted in the frequent “loss” of policy makers who have been sensitized on HSR. This was compounded by the fact that consensus building had not taken roots to be a continuous process in countries.

Development of HSR Skills

The HSR Project has trained a total critical mass in HSR methodology of nearly 1800 provincial and district health workers. This represents a small proportion of nationally-organized and funded training at country level.

The HSR training methodology had built into the process a practicum through the application of skills with the actual preparation and implementation of a HSR proposal. However, completing one research study as part of the HSR skills training is simply an initial step in the long and continuing process of acquiring and mastering these skills. These are sharpened with every research conducted. Mobilization of resources to meet the research needs is a big challenge that has yet to be considered as a priority task of the Ministries of Health.

Training and research institutions formed an alternative entry for institutionalizing HSR training, but coordination remained weak. HSR has been integrated in the curricula of three Universities (Tanzania, Zambia and Zimbabwe); the level of HSR development in these Universities is variable. In other academic institutions, this has been at the discretion of individual faculty members. An assessment of HSR training conducted in the schools showed that most used traditional training methods and did not include modern technology. There was also inadequate use of participatory, multi-disciplinary and action-oriented approaches in research training. In all 11 training institutions evaluated, there was a common problem of availability of time to do research because of crowded curricula and a lack of adequate skills in modern and efficient training techniques.

Research Conduct and Application of Research Evidence

One of the assumptions of the HSR project in empowering the middle and lower levels of health care provision/management with HSR skills was their opportunity to use these in investigating and solving the most pertinent and pressing problems, would contribute to the improvement of the health of the populations. The HSR Project has not been able to keep track of the extent and frequency of application of skills by the trained cadre as well as the impact of HSR training. Looking at the implementation of recommendations has received limited attention in the project. The opportunities for the conduct of HSR has been limited for most of the critical mass trained on HSR primarily due to the lack of financial

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9 Ndeki, S. S. A Regional Assessment of HSR Training in Eastern and Southern Africa.
resources allocated for national HSR activities. Since these workers are also doing their routine activities, the time available for research may also be limited.

That only 50% of research results were reportedly used, point to the need for more active participation and team-work among policy makers, managers and researchers in prioritizing of HSR issues; planning and implementing HSR studies as well as more advocacy and user-friendly dissemination methods. An external evaluation of the HSR Project concluded that although only half of research recommendations are implemented, this does not necessarily represent a failure of the project since numerous factors affect the possibility of implementation. Nevertheless, it was agreed that the promotion of implementation should receive greater attention\textsuperscript{10}.

Since the majority of health workers who have been trained on HSR came from the district and regional levels of the health sector, it was expected for most studies to have focused on operational issues and have had less impact on health policy than expected. The main reasons for the failure to implement were given as a lack of resources and the failure to adequately involve policy and program implementers in the research process\textsuperscript{11}. Health managers and policy makers were often unaware of results of studies done at district level, partly due to their frequent turnover and the failure to evolve common research priorities. On the other hand, very few of those trained in HSR have actually taken advantage of the opportunities to submit proposals for funding by the HSR project outside of the training. Moreover, there has also been a lack of initiative in terms of team approach and/or research collaboration involving health staff, researchers from research and/or academic institutions. While highly desirable, this ideal team work and partnership has seldom materialized unless required in calls for proposals that funding agencies issue from time to time.

An external evaluation reported that in each country there are a considerable number of external initiatives supporting research including operational research, particularly at Universities\textsuperscript{12}. Some departments are more popular than others; other departments or institutions are left out. A more serious issue is the lack of local input in project conceptualisation, leading to isolated projects that are not integrated with or understood clearly by departments. Sustainability is not properly addressed together with poor implementation.

Network and Collaboration

This was evident throughout the HSR project, from its planning to implementation, at all levels: international and country levels; in the training of health teams and HSR materials development; in the conduct of studies; in publications; as well as in the project evaluation. The motivations for networking varied and these applied both at the level of the HSR Project and at country level.

That which involved the HSR Project, the participating countries and external partners has been effective in facilitating the mutual exchange of experience and expertise as well as in mobilizing resources. Networking has been achieved by involving specific organizations and institutions (both public and private, e.g. AMREF, CRHS, ECSACON), other HSR initiatives (e.g. GTZ HSR Program on Reproductive Health), information and professional networks (e.g. SOMANET).

\textsuperscript{11} Peer Review of the Joint Project. 1993.
\textsuperscript{12} Ndeki, S. S. A Regional Assessment of Health Systems Research Training in Eastern and Southern Africa.
On the other hand, “networking” within countries, and even within single institutions, including Universities, has been inadequate according to one external evaluation. It also noted the tendency of single individuals to act as “focal point person” for even more than five projects and organizations as well as unnecessary duplication of efforts in the organization of workshops and training. Links among departments in university and non-university departments including the MoH are weak and informal. The potential of HSR Focal Points for initiating and supporting collaboration has not been fully exploited.

It was recommended that efforts should continue at country level to strengthen information sharing, coordinate activities and foster collaboration in order to reduce costs and lighten the workload of research managers. It encouraged the exploration of electronic communication in all aspects of HSR programs. More funding and innovative skills are also called for in initiating and developing HSR collaboration among departments. Coordination of research within countries and among institutions needs better infrastructure and streamlining to avoid duplication.

Revisiting The HSR Strategies

The above limitations called for a review and recasting of the HSR strategies and activities in order to meet its objectives more effectively and efficiently, which to date have remained valid.

Another important consideration is the ushering in of the new millennium with a strong endorsement by the WHO on the urgent need for health systems to respond with greater compassion, quality and efficiency to the increasingly diverse demands they face. The choice of interventions by any health system needs to take account of research into its effectiveness in order to ensure the development of an optimal strategy. An open and informed debate about priorities in health is also a necessary part of this strategy. Informing this debate is a critical task for research.

HSR Strategies for the Second Decade of Implementation

Ensuring adequate commitment to research and development is an integral element of health systems development. In WHO/AFRO, this must be viewed within the context of the key program areas which have been adopted in response to priority health and related problems in the region: rollback malaria; HIV/AIDS/STI; tuberculosis; reduction of maternal and child morbidity and mortality; health sector reform. Regional implementation frameworks have been adopted in each key area, with strategies and interventions that would lend themselves well to the identification of common HSR agenda, priorities for HSR and the development of framework for multi-country studies. Working towards a collective research goal is an economically rational approach and would necessitate investment of relatively modest sums for inter-country activities for the aggregate efforts that would substantially benefit these countries. Regional research would exceed the sum of national efforts, not only in quantity but also in quality of results.

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13 Ndeki, S. S.
15 Ndeki, S. S.
In light of the above, the HSR Program is faced with the monumental challenge of compressing the time required to contribute significantly to accomplishing the goals of the health systems within the first biennium of the first decade in the 21st century.

Towards this end, a new approach to HSR capacity strengthening had to be developed, taking stock of the lessons learnt during the first decade of HSR implementation. This called for recasting of the HSR strategies taking into consideration the readiness of participating countries, the key program priorities of the region, the increasing demands for effective and efficient performance of health systems.

The WHO/HSR Program, has shown during its first decade as a project, real commitment towards enabling member states to more equitably use HSR as a powerful tool for accelerating health improvements in general and the performance of the health system in particular. This was achieved through a combination of essential and complementary strategies for national HSR empowerment: institutional building, HSR capacity strengthening, application of skills through the conduct of research on priority issues and promoting the use of results. By so doing, it attempted to address some of the basic causes of inequalities in research.\(^{18}\)

A similar package of approaches would be developed by recasting the initial strategies of the HSR project which to date remain valid. There will be stronger emphasis on strengthening national and inter-country networking, in focusing on key regional problem areas as entry point for participatory HSR prioritizing, in HSR agenda-setting and planning of HSR studies including multi-country studies, with concrete national plan for country-specific implementation.

**Comparison of HSR Strategies: First and Second Decades of Implementation**

Table 2 presents a comparison of the overall strategies and activities between the first decade of HSR project implementation and the second decade. It is noted that the same objectives prevail. Since 1998, the HSR program concerns gradually moved into the strengthening and sustaining of national HSR institutional capacity. HSR skills development has veered away from the organization of inter-country training on HSR organized and funded by the HSR project. Instead, technical support is provided to courses organized by countries, or in response to externally funded training. Partnership between the HSR Program and national/regional priority program areas such as health sector reform and HIV/AIDS is being developed with the end in view of identifying the needs and gaps for HSR, establishing research agenda and formulating research frameworks on key problem areas with regional impact. Another principal target is the documentation of at least a decade of HSR experience through the development of regional tools for HSR establishment/strengthening and or maintenance.

Table 3 presents a framework of recast HSR strategies focused specifically on prioritising and conduct of HSR and strengthening of HSR. It is presented along side the original strategies to demonstrate the revision.

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Oxford University Press. p. xviii.
Table 2. HSR Project objectives, strategies, activities: Comparison between the 1st and second decade of implementation

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<td><strong>OBJECTIVE # 1 : To strengthen national institutional capacity on HSR</strong></td>
<td><strong>Strategies</strong></td>
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<tr>
<td>  Advocacy for awareness &amp; consensus-building</td>
<td>  Strengthening HSR institutions (focal points and HSR Units)</td>
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<td>  Strengthening HSR institutions (Focal Points, HSR Units)</td>
<td>  Experience-based development of package of tools on HSR</td>
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<td><strong>OBJECTIVE # 2 : To build national capacity on HSR methodology</strong></td>
<td><strong>Strategies</strong></td>
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<tr>
<td>  Development of standardized HSR training materials &amp; methodology</td>
<td>  Technical support to countries' capacity building through national-organized HSR training, TOTs; integration of research in selected curricula.</td>
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<tr>
<td>  Training of health &amp; related staff, researchers</td>
<td>  Technical support to national HSR capacity building.</td>
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<td>  Training of trainers (TOT)</td>
<td>  Technical support to research studies.</td>
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<td>  Integration of HSR in selected curricula.</td>
<td>  Promote multi-country and country-specific studies.</td>
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<td><strong>OBJECTIVE # 3 : To support the development and implementation of HSR proposals</strong></td>
<td><strong>Strategies</strong></td>
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<tr>
<td>  Technical support</td>
<td>  Technical support to inter-country HSR prioritizing and agenda-setting on key regional program areas.</td>
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<td>  Financial support to the conduct of research</td>
<td>  Technical and financial support to research studies.</td>
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<td>  Encourage &amp; support qualified proposals from countries</td>
<td>  Promote multi-country and country-specific studies.</td>
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<td><strong>OBJECTIVE # 4 : To promote utilization of HSR results as evidence for decision-making</strong></td>
<td><strong>Strategies</strong></td>
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<tr>
<td>  Involvement of decision-makers in prioritizing &amp; planning of HSR protocols</td>
<td>  Participatory, inter-country and team approach to research prioritizing, agenda setting and development of HSR frameworks on key regional problem area.</td>
</tr>
<tr>
<td>  Build-in plan on use of results within HSR protocol &amp; report</td>
<td>  National POAs for inter-sectoral &amp; team approach in implementation of HSR agenda; HSR studies.</td>
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<tr>
<td>  Support plan implementation</td>
<td>  national POAs for inter-sectoral &amp; team approach in implementation of HSR agenda; HSR studies.</td>
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<td>  Dissemination activities</td>
<td>  Public dissemination activities e.g. Open Research Day in countries.</td>
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<td><strong>OBJECTIVE # 5 : To facilitate exchange of experience on HSR, networking and TCDC</strong></td>
<td><strong>Strategies</strong></td>
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<td><strong>Networking:</strong></td>
<td><strong>Networking.</strong></td>
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<tr>
<td>  Within country</td>
<td><strong>Publications</strong></td>
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<tr>
<td>  Among participating countries</td>
<td><strong>Linkages with external partners.</strong></td>
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<td>  With international agencies</td>
<td><strong>Inter-country planning &amp; exchange of experience.</strong></td>
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<td>  Other donors</td>
<td><strong>Publications</strong></td>
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<th>ISSUES</th>
<th>ORIGINAL STRATEGIES</th>
<th>RECAST STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic assumptions</td>
<td>• Focused on establishing or strengthening national capacity for HSR through the training of health staff on HSR methodology. • Inter-country training more expensive but quick method to provide countries with core teams trained on HSR.</td>
<td>• Principal focus is to generate evidence through HSR on a priority regional problem or program area. • Inter-country or regional planning is an economically rational approach; results would exceed the sum of national efforts in quantity and quality of results. Country experiences and POAs provide element of country specificity in the further development and implementation of outcomes. • Important by-product is acquisition/strengthening of skills on HSR methodology through learning by doing approach.</td>
</tr>
<tr>
<td>Objective and expected outcomes</td>
<td>• Capacity building among health and related staff on HSR methodology. • Outcomes achieved over a period of about 8 months to one year: - HSR proposal developed; conducted; - HSR report - Plan to promote implementation of recommendations. • Acquisition of introductory HSR skills by the health staff</td>
<td>• Objective and expected outcomes reflect a process that starts with the identification of gaps and priorities in HSR on the key program area under consideration; development of a common research agenda and HSR frameworks on the top HSR issues. • The HSR frameworks are to guide the preparation of research protocols aimed at improving the efficiency and responsiveness of (district) health systems related to the particular key program area. • List of multi-country studies is evolved. • Preparation of country POAs to implement the outcomes provides specificities to the regional activity and basis for country implementation and follow-up support by the HSR program.</td>
</tr>
<tr>
<td>Participants</td>
<td>• Level</td>
<td>• Multi-provincial, district level health staff; some representation by University or other relevant institution</td>
</tr>
<tr>
<td>Problem selection; research types and methods</td>
<td>• Team to be trained selected HSR topic among problems encountered in work situation in consultation with supervisor, colleagues, community. • Mostly based on operational problems; • Majority are descriptive, KAP – focus at operational level</td>
<td>• Overall focus is key problem in the Region shared by the countries. • HSR priority issues selected following analysis of available research and gaps; analysis of interventions in place in countries and research questions using WHO framework on health system performance assessment. • Prioritizing process followed. • Stronger focus on policy-related research • Encourage variety of methods including policy-oriented research; policy analysis, evaluative studies, impact studies; multi-country studies.</td>
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<tr>
<td>Process, methodology</td>
<td>• Participatory; based on standardized HSR methodology • Training spread over three phases over a period of 8 months to one year.</td>
<td>• Participatory; only brief overview of HSR methodology to provide common framework among participants • Immediate application of HSR concepts and principles on key problem area through working groups assigned different facets of the problem/program. • Plenary presentations and discussions provide holistic view of the HSR issues re various facets of the key program area. • Inter-country consultations lasted for 4 to 5 days.</td>
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<tr>
<td>Implementation of HSR recommendations</td>
<td>• Build into HSR proposal and in final report. • Teams implement in their respective work situation a plan to promote implementation of HSR recommendations.</td>
<td>• Implementation of HSR recommendations built-in into country POAs on implementation of Consultation outcomes and specific HSR proposals. • Also included in the WHO/AFRO/HSR regional plan to follow-up implementation of country POAs. • Continuing partnership and involvement of researchers, policy makers and program managers/implementers throughout the process is expected to facilitate implementation of HSR recommendations.</td>
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<tr>
<td>ISSUES</td>
<td>ORIGINAL STRATEGIES</td>
<td>RECAST STRATEGIES</td>
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<tr>
<td>Resource mobilization</td>
<td>•</td>
<td>• At regional level, WHO/AFRO/HSR works closely with staff responsible for the key program area both for technical and financial reasons.</td>
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<tr>
<td></td>
<td>• Selected external partners involved in key problem area are invited from the start</td>
<td>• Selected external partners involved in key problem area are invited from the start to facilitate continuing support including funding.</td>
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<td></td>
<td>to facilitate continuing support including funding.</td>
<td>• Build-into the country POAs and WHO/AFRO/HSR regional follow-up plan.</td>
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<td></td>
<td>• Build-into the country POAs and WHO/AFRO/HSR regional follow-up plan.</td>
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<tr>
<td>Follow-up support</td>
<td>As part of the training, HSR project provided:</td>
<td>• Pro-active package of follow-up support by WHO/AFRO/HSR looks into the application of HSR skills, proposal development and implementation.</td>
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<tr>
<td>including resource</td>
<td>• Technical support in the proposal development, implementation and report writing.</td>
<td>• Involves established national structures through the WHO Representative;</td>
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<tr>
<td>mobilization</td>
<td>• Funded implementation of proposal.</td>
<td>• Makes use of established HSR project support activities e.g. regional meeting of HSR/FPs to monitor and provide additional technical inputs based on identified limitations in country POAs.</td>
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Examples of Application of Framework for Recast HSR Strategies

Given the above framework, the WHO/AFRO/HSR program has organized two inter-country activities where the recast strategies have been applied. The first was a consultation on HSR priorities on health sector reform; the second on HIV/AIDS HSR priorities.

Consultation on HSR Priorities on Health Sector Reform

Research has begun to provide clearer evidence of the economic benefits of improving health. It has also shown that the effects (on productivity) of improved health have been found to be greatest for the most vulnerable, i.e. the poorest and those with the least education.

One of the identified tasks requiring international collective action is ensuring that critical research and development for the poor receives funding. The WHO has identified this among the guidelines for it to make a difference in its work on international health.

It was therefore not surprising that during the HSR Consultation on health sector reform the 5 inter-country teams of researchers and decision-maker/managers involved identified an equity issue as a priority area for HSR multi-country study. The objective of the consultation was to develop a research proposal for conducting a multi-center comparative study on health sector reform in order to contribute to the accumulation of evidence for policy decisions on the development of reforms in the 5 African countries. The outcomes were: i) a list of operational research issues that affect the implementation and sustainability of health sector reform; ii) a draft multi-center study proposal for comparative research; iii) a plan of work for the organization, conduct, monitoring and funding of the study and dissemination of results. The topic selected was on effective exemptions and waiver mechanisms that ensure equitable access to health care by the poor and vulnerable.

Some of the key observations and lessons learnt from this activity included:

Composition of participants: Pairing off of health managers involved in health sector reform and experienced researchers facilitated the difficult task of identifying and prioritizing HSR issues, developing a full HSR proposal within a very short period (4 – 5 days). This was assisted by brief presentations on the steps of HSR proposal development. While it is recognized that at least half of the participants were trained researchers, the presentations ensured a common HSR framework especially among the health managers as well as among the researchers some of whom had not trained specifically on the HSR methodology.

Prioritizing of research issues. The participating countries sent in advance their suggested priority HSR issues. Together with other issues noted during the country presentations, these formed the basis for prioritizing of health sector reform issues requiring research. The choice of research topic was therefore wide open given the nature of health sector reform implementation. Following the nominal group technique, the workshop identified these top research issues: a) viable financing mechanisms for health services to ensure the protection of poor and vulnerable groups; b) role of hospitals in health sector reforms and mechanisms for improving their efficiency; c) the impact of user charges on utilization and quality of health services.

Process of proposal development. The participatory process of proposal development was based on the framework for HSR. The step-wise presentation of concepts on HSR proposal development combined brief theoretical input and immediate application thus enabling the participants to prepare each section of the proposal. The plenary sessions and discussions were useful in the peer-group review and revision of each section.

In-country implementation of the proposal called for each country team to plan together a country-specific budget and schedule.

Consultation on HSR Priorities on HIV/AIDS

The AIDS epidemic typifies the need for a global response demanded by a global challenge. The regional framework on HIV/AIDS strategies and activities has been adopted by countries.

In organizing the inter-country consultation on this topic, lessons learnt from the first consultation on health sector reform were taken into consideration. The Consultation focused on the responsiveness of health systems to HIV/AIDS. The overall objective was to identify gaps and priorities on HSR on HIV/AIDS and develop HSR frameworks that will guide the preparation of research protocols aimed at improving the efficiency and responsiveness of health systems in the control of HIV/AIDS at the peripheral level. The expected outcomes were: an overview of major HSR studies on HIV/AIDS carried out in these countries; list of prioritized HSR needs and gaps on HIV/AIDS; an HSR agenda and research frameworks; list of possibilities for multi-country studies; national plans of actions to implement the outcomes.

The 28 national participants were researchers, experts and managers experienced/involved on HIV/AIDS. The 13 countries that participated are among those with the highest rate of HIV/AIDS globally. Thus, the topic was considered top priority by all with high level participation from both the National AIDS Control Programs (NACP) and researchers or epidemiologists from the health sector. This also took place at a time when WHO was launching its new framework on health systems performance. It served as a basis for identifying gaps in HIV/AIDS interventions in countries and organizing the potential areas for HSR according to the four functions of the health system: stewardship, financing, provision of care and resource generation.

The consultation was successful in achieving its set objectives and expected outcomes. It was evaluated very highly and all the countries expressed their wish to participate in multi-country studies on the topics that they had prioritized and for which HSR frameworks were developed. A comprehensive list of possible areas for HSR was compiled within the context of the HIV/AIDS interventions in place in countries and organized as a HSR agenda according to the four functions of the health system. A short list of priorities was evolved and out of these, the top five were developed into HSR frameworks:

♦ Evaluation of strategic plans on HIV/AIDS
♦ Quality of care provided to HIV/AIDS patients in health facilities.
♦ Cost of care to families on the home care of PLWA
♦ Cost sharing – how families are financing the care of PLWA


Comparative availability of drugs among PLWA and those without.

Specific country POAs were developed to implement the consultation outcomes. The external partners represented equally expressed interest in participating in the follow-up with possibility of funding. There was a strong suggestion for the immediate implementation of the consultation follow-up activities.

*Lessons learnt and the way forward:*

Both Consultations were successful with the second on HIV/AIDS HSR priorities having benefited more from insights gained during the first Consultation. Available studies on HIV/AIDS are not generally compiled and analyzed in countries thus losing the opportunity to learn from the evidences generated by research. Duplication could also occur with some topics being more over-studied than others. The quality of many KAP-type of studies generally needed improvement. The country POAs will be useful in following-up countries in implementing outcomes of the consultation. The most common constraint faced in the implementation of country POAs is limited HSR skills and funding. Networking is a constraint identified in several countries.

The composition of participants in the consultation is expected to comprise of equal number of HSR-trained researcher and of policy maker, program manager or implementor. The selection of participants is done by the MoH based on a profile provided by the HSR program. The desirable composition is never obtained. Thus, at the HIV/AIDS consultation, five countries sent only technical staff involved in the HIV/AIDS program; only 5 out of expected 13 nationals were trained on HSR.

WHO/AFRO/HSR has put together a pro-active regional package to support the implementation of national POAs. Concrete recommendations for follow-up and support by the WHO/AFRO/HSR will involve the existing national structures and mechanisms concerned with the HIV/AIDS problem – to be spear-headed by the WHO Representative in each country working in collaboration with the Ministries of Health and the UN AIDS theme groups. Another important activity is a regional meeting to orient all national HSR/Focal Points in the Region on the outcomes of the consultation and planning for the implementation of POAs as well as provision of technical inputs to bridge the gap on lack of skills related to policy-oriented research.

It is noted that in a third of the countries that participated in the HIV/AIDS Consultation, concrete steps had been taken to initiate the implementation of the national POA and feedback has been provided to the WHO/AFRO/HSR Program. At regional level, WHO/AFRO/HSR program has taken steps to implement the regional meeting of HSR/FPs. At least one external partner involved at the original consultation is providing technical and financial inputs.

**CONCLUSIONS**

The experience so far gained in the limited application of the framework of recast HSR strategies point towards a favorable change in the response to HSR program interventions. The key words in the recast HSR strategies bring together concepts of participatory process involving stakeholders starting with planning, research prioritizing; creating opportunities using key problem areas to facilitate teamwork in the conduct of HSR; package of follow-up support, supportive mechanisms and networking throughout the HSR process. Based on this experience, the following conclusions are made.
Basic assumptions. Inter-country consultations provide an effective and economically rational means for the exchange of experiences, joint planning and learning from each other on a key program area of regional importance. It is important to envision the package of activities that are associated with this initial step in the intervention that could serve as entry point towards a combined knowledge base building, HSR capacity strengthening and contributions towards solving key health problems. These call for investment in time and money which all the more require planning of the change. Part of this planning is identifying common frameworks that would facilitate participation and in the case of the HIV/AIDS consultation, these were: a regional framework of HIV/AIDS and strategies/interventions adopted by the countries; WHO framework on health systems performance and their assessment; framework for HSR proposal development.

Objectives and expected outcomes. A comprehensive set of objective and expected outcomes as listed in the inter-country consultation requires a great deal of planning and complex process in its implementation. Each outcome is however essential and contributes towards a rational approach that builds into each subsequent consultation outcome.

Meeting of the expected outcomes can only be fully achieved with the participation of countries. Based on experience from both consultations, one of the limitations has been the inability of countries to compile and analyse available research studies on the particular areas under consideration. This is a new activity that has yet to be instituted in most countries. Thus, the identification of research gaps based on available research requires much lead time if the true picture is to be obtained in time for subsequent events.

Participants. Having the right partnership among researchers, policy makers and program managers and implementers who are provided with the opportunity to actively participate in the HSR process, contributes to teamwork. This in turn requires nurturing throughout the completion and application of HSR study findings and recommendations. This is important in ensuring the relevance of the HSR topics, quality of research and more importantly the application of evidence into decision-making.

The desired final composition of the participants who attend the inter-country or regional consultations is difficult to achieve and this is likely to affect the implementation of follow-up activities in countries. This is an important consideration in planning the follow-up support to countries in order to bring in other stakeholders to participate in the process.

Problem selection and research types/methods. HSR as a technical support, is best integrated into carefully selected health programs that represent key areas of regional importance. This can serve as entry point for marketing HSR as a management tool that is relevant, useful and worth the resource investment by stakeholders including decision-makers and external partners. This is heightened by the participation of countries that are in the forefront of the problem area under consideration. These countries share common implementation frameworks that could be jointly analyzed on the basis of the WHO Framework on health system functions and their performance.

Arising from this analysis, a variety of research types including policy-oriented research was identified in the second consultation. Towards this end, the analysis of available research in countries and recommendations to broaden the research types was very useful.

Process, methodology. Learning by doing starts with the brief overview of HSR concepts, so that what could be a complex HSR methodology, would be simplified and applicable, even among those with minimal research exposure. This is facilitated by immediate application in topics that are important and familiar to
the participants, practical and touching on their work, thus also providing intrinsic motivation. The immediate peer-review provided by the plenary sessions and discussion of group work results is also very useful.

*Implementation of HSR recommendations.* The importance of this could not be overemphasized in the consultation. Its entire planning aimed to positively influence decision-making on policies and programs as reflected in the composition of participants, choice of topics, country POAs and follow-up support. The experience to date on the recast strategies does not provide further insight into this.

*Follow-up support including resource mobilization.* Inter-country and regional activities only serve to bring the national teams together, learn from the exchange of experiences and joint planning. Eventually this leads to country-specific POA that would be the responsibility of each national team to implement and to ensure multiplier-effect internally. WHO/AFRO in turn has to ensure follow-up and monitoring in countries and provide multiplier-effect to other member states.

Given the limited resources allocated to health research, internal decision-makers and external partners need to be brought along in the process from the start of the consultation. It is easier to mobilize resources when each one sees the value, advantages of HSR and its products, into their respective work and personal agenda. The regional level provides seed money to initiate and facilitate the HSR process. Each country eventually has to mobilize its own resources to implement its POA.

A pro-active package of follow-up support needs to be well planned, prior to the intervention. This should however be flexible enough cognizant of changing needs in countries and among external partners. This should consider political commitment and the availability of a research plan/agenda and provision of catalytic funds to facilitate and sustain the process.

Finally, HSR methodology and its value have begun to take roots in countries of the region. A regional institution such as WHO/AFRO, through its HSR Program, has an important catalytic role in ensuring that HSR is continuously applied as a management and development tool, for generating and applying knowledge base in policy and program decisions. It is strategically placed to promote and support the conduct of inter-country interventions including multi-country studies, that offer the advantages of efficiency in resource utilization, learning through the exchange of experiences and joint planning, improved quality of health systems research output and with all affected countries sharing the fruits of research and development.

*Return*