

Making health systems research work: time to shift funding to locally-led research in the South



This week, the global health systems research community is gathered in Vancouver, Canada, for the Fourth Global Symposium on Health Systems Research. The current movement for health systems research developed out of a need to strengthen health systems in low-income and middle-income countries. More than 25 years ago, the Commission on Health Research for Development published a report that represented a pivotal change in thinking about health research for development.¹ The main argument of the report was that research contributed little to health in low-income and middle-income countries, because it matched poorly with needs in the global South, was dominated by researchers from the North, and had a narrow biomedical focus.

While health systems research has taken off in some high-income countries, progress in low-income and middle-income countries has not kept up.² The 2008 Global Ministerial Forum on Research for Health in Bamako, Mali, concluded with the recommendation to increase investments in health systems research and organise a global symposium specifically focused on improving health systems in low-income and

middle-income countries.^{3,4} Since then, the field has expanded rapidly.⁵

To contribute to the debate concerning the status and future of the health systems research field, we assessed the research presented at the previous global symposia. We systematically analysed the 1816 abstracts that were presented at the global symposia in Beijing (2012) and Cape Town (2014) and the participant lists of the Cape Town, Beijing, and Montreux (2010) symposia.

Our findings present several promising developments but also highlight that research inequities persist. While we observe a gender balance (51% of first authors are female) and substantial contributions from countries such as India, China, and South Africa, the North-South imbalance that was described 26 years ago remains.

The figure shows the countries in which most primary data have been collected and the countries in which most first authors were based. While 96% of the primary data were collected in low-income and middle-income countries, 56% of first authors were based in high-income countries, compared to only 8% in low-income countries. An even more striking, and largely neglected, imbalance is that health systems research mainly takes

Lancet Glob Health 2016
Published Online
November 16, 2016
[http://dx.doi.org/10.1016/S2214-109X\(16\)30331-X](http://dx.doi.org/10.1016/S2214-109X(16)30331-X)

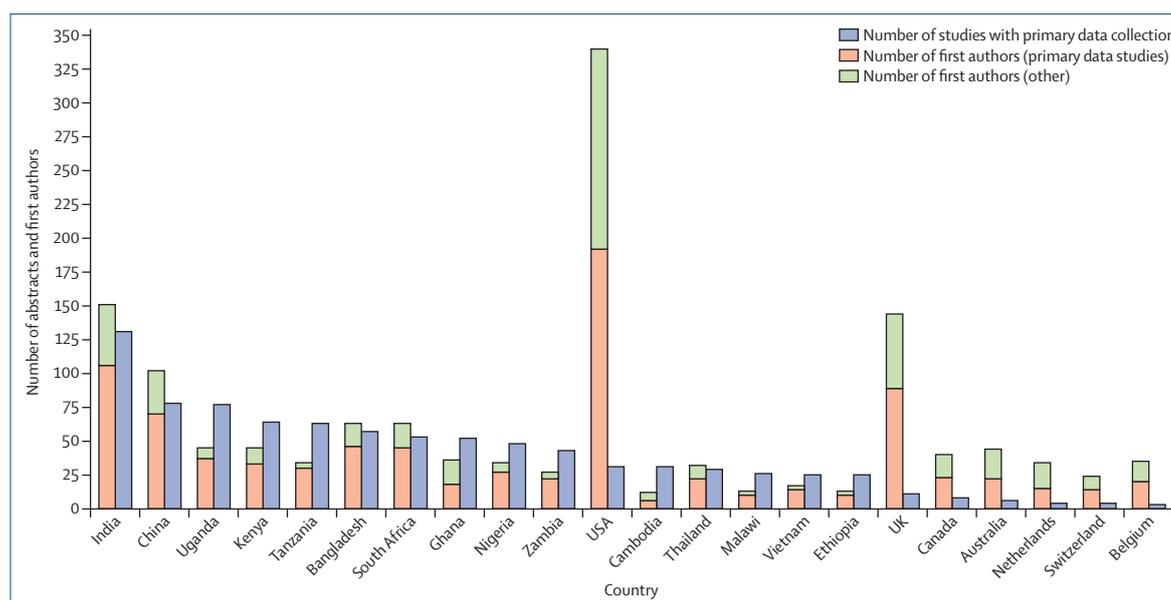


Figure: Ranking of countries based on the number of abstracts involving primary data collection
Chart combines the top 16 countries in which data were collected with the top 16 countries in which the first authors were based.

place in countries where English is one of the languages used by government. In nine of the top ten countries in which most data were collected, and in nine of the top ten countries most first authors came from, government officials predominantly use English.

When compared to countries in which health systems can be studied in English, the contribution and participation of the rest of the world is rather limited. Not a single study from Russia was presented, only 3% of the participants came from South or Latin America, and more than a third of the world's countries were not represented at any of the global symposia. The number of primary studies per citizen from a country such as Indonesia is about 25 times smaller than countries such as Uganda, Kenya, or Zambia. The inequities in the research presented at the global symposia are similar to those seen in published health systems research.^{2,6}

The prominent role of some Northern high-income countries is problematic for a research movement that aims to contribute to improving health systems in low-income and middle-income countries worldwide. Empirical studies in the South consistently show that health research is most likely to be used when it is aligned with local needs, embedded in a local infrastructure that facilitates its use, and led by local researchers who regularly interact with potential users and are keen, able, and available to help translate results into local action.^{7,8}

Besides increasing the likelihood that results are used, health systems research that is led by locally embedded researchers is also more likely to be of higher validity. Studying health systems requires extensive knowledge of the specific local circumstances, trustful relationships with key actors in the system, and local language proficiency.⁹ While foreign researchers can acquire each of these, it is more effective and efficient for local researchers to study their own health system. A third reason why health systems research in low-income and middle-income countries is best conducted by local researchers is that conducting research is essential to further developing local research capacity. As long as development funding is used to send researchers from the North to study health systems in the South, research capacity is not strengthened where it is most needed.

The essence of the solution to this imbalance is straightforward: increase funding for demand-driven and locally led research in the South. In the short term,

this can be achieved by increasing the proportion of funds allocated to research led by the South. These funds should be channelled through nationally embedded programmes because this increases both the effectiveness and efficiency of investments in development. In the long run, it is crucial to bolster the social contract between research and society in low-income and middle-income countries. One way to support this is to encourage co-investment from national governments, ensuring that research is aligned with national priorities and results are translated into action.

While in several countries the capacity for health systems research needs to be strengthened, there are important signs that existing capacities are underused. Research capacity is often evaluated by counting publications or faculty positions. This, however, says more about a lack of funding than a lack of capacity.^{2,10} There are examples that show that a latent reservoir of health research capacity exists in low-income and middle-income countries, which flourishes when funding for local research increases. In Ghana, for instance, a research programme provided funds for local research, prompting an increase in the number of proposals submitted annually from 13 to 99 between 2001 and 2006.^{7,11}

Shifting funding to nationally embedded programmes is essential for building a health systems research community beyond English-speaking countries and reducing the dependency on Northern scholars with limited language abilities beyond English. North-South collaboration can be helpful, as long as locals take the lead and choose their own partners, and cooperation is based on mutual respect.

**Amalia Hasnida, Robert A Borst, Anneke M Johnson, Nada R Rahmani, Sabine van Esland, Maarten O Kok Migunani Network, Yogyakarta, Indonesia (AH); Institute of Health Policy and Management, Erasmus University, Rotterdam, Netherlands (RAB, MOK); Department of Health Sciences, VU University Amsterdam, Amsterdam, Netherlands (AMJ); Clarity for Development, Bandung, Indonesia (NRR); Department of Paediatrics and Child Health, Faculty of Health Sciences, Stellenbosch University, Stellenbosch, South Africa (SVE) amalia.hasnida@gmail.com*

We declare no competing interests.

© The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY license.

1 Commission on Health Research for Development. Health research, essential link to equity in development. Oxford: Oxford University Press, 1990.

- 2 Adam T, Ahmad S, Bigdeli M, Ghaffar A, Röttingen J-A. Trends in health policy and systems research over the past decade: still too little capacity in low-income countries. *PLoS One* 2011; **6**: e27263.
- 3 Bennett S, Adam T, Zarowsky C, et al. From Mexico to Mali: progress in health policy and systems research. *Lancet* 2008; **372**: 1571–78.
- 4 Ghaffar A, Tran N, Rottingen J-A, Kieny M-P. Health policy and systems research: building momentum and community. *Bull World Health Organ* 2015; **92**: 851–51.
- 5 Ghaffar A, Gilson L, Tomson G, et al. Where is the policy in health policy and systems research agenda? *Bull World Heal Organ* 2016; **94**: 306–08.
- 6 Yao Q, Chen K, Yao L, et al. Scientometric trends and knowledge maps of global health systems research. *Health Res Policy Syst* 2014; **12**: 26.
- 7 Kok MO, Gyapong J, Wolffers I, Ofori-Adjei D, Ruitenber J. Which health research gets used and why? An empirical analysis of 30 cases. *Health Res Policy Syst* 2016; **14**: 36.
- 8 Brambila C, Ottolenghi E, Marin C, Bertrand JT. Getting results used: evidence from reproductive health programmatic research in Guatemala. *Health Policy Plan* 2007; **22**: 234–45.
- 9 Bennett S, Agyepong IA, Sheikh K, Hanson K, Ssengooba F, Gilson L. Building the field of health policy and systems research: an agenda for action. *PLoS Med* 2011; **8**: 1–5.
- 10 Gonzalez Block MA, Mills A. Assessing capacity for health policy and systems research in low and middle income countries. *Health Res Policy Syst* 2003; **1**: 1.
- 11 Wolffers I, Adjei S. Research-agenda setting in developing countries. *Lancet* 1999; **353**: 2248–49.