“...to become more relevant for the health systems and communities that are their intended beneficiaries, Global Health practices must actively span and disrupt boundaries of geography, geopolitics and constituency, some of which are rooted in imbalances of power and resources.” (Sheikh et al. 2016, p.2).

As global actors reorient funding and health interventions around Agenda 2030, the field of Health Policy and Systems Research (HPSR) will play an important role in facilitating shifts in power and priorities to reflect current health system realities. This will require responses to challenges that are guided by two principles. Firstly, decision-making, leadership, and capacity-building must prioritise actors and perspectives from the global South. Secondly, advancing the field of HPSR will require strategies to expand current boundaries that limit true interdisciplinarity and alternative perspectives in both HPSR teaching and practice.

As young professionals motivated by commitment both to rigorous, enterprising research, and to the principles of equity and social justice, we argue that HPSR researchers, lead by the Alliance for Health Policy and Systems Research (the Alliance), have a moral duty to look inwards and recognise the power imbalances that pervade the discipline. This requires that global organisations and individual researchers recognise their role in sustaining modes of operation that contribute to and perpetuate inequalities in health outcomes and access to quality care. Not only do they need to remain cognizant of this power imbalance, but they must also advocate against it and actively counter it in their daily practice of HPSR.

The Alliance, HPSR, and Agenda 2030

Established at a time when the international health and development aid communities, particularly in the context of low- and middle-income countries (LMICs), focused on programmatic interventions, the Alliance has become a respected leader in the field of HPSR, and has demonstrated the importance of strengthening overall health systems for better outcomes in LMICs. As shifts in donor priorities, power balances between countries in the global North and South, and paradigms in health research, the role of
the Alliance is more important than ever to sustaining and building on the gains made over the last two decades.

HPSR has made considerable progress in growing and strengthening its disciplinary foundation. Not only does it now include a broader range of stakeholders, but it has achieved more prominent visibility among global health researchers and policymakers. For example, the formation of Health Systems Global (HSG) and associated symposiums has provided a robust forum for collaboration, networking and knowledge sharing between health system actors across the globe. The diversity in topics and attendees at HSG’s fourth global symposium in Canada in November is further evidence of this.

Constrained health systems and a general lack of information to guide policy decisions and implementation has greatly impeded the successful achievement of previous development goals. By leveraging the Alliance and the World Health Organization (WHO) platform, the HPSR field has been instrumental in placing universal health coverage, supported by resilient, responsive, and effective health systems, and the need for increased systems research on the global agenda. The Sustainable Development Goals (SDGs), as an expression of the principles of Agenda 2030, represent advances in international health development rhetoric by reflecting a shift from global to national targets, making room for context specificity and adopting a systems perspective.

Despite this progress, vast inequities in both the provision of services and health status remain. These inequities not only reflect the economic milieu of countries, but also the global imbalance in power and skewed provision of development aid that has emerged as an unintended consequence of the Millennium Development Goals (MDGs). Empowering and meeting the needs of health systems in LMICs, particularly in the global South, has not been wholly successful. Northern agendas and ideologies prevail, with guidelines and aspirations largely based on data from developed countries (Hasnida et al. 2017). Furthermore, failing to account for local health system constraints and the economic and social realities of LMICs has impeded success. As HPSR researchers and relevant stakeholders turn their attention to the SDGs, they would do well to heed these and other critical challenges moving forward.

Challenges

Agenda 2030 presents numerous opportunities for change in the field of HPSR. Not only is it a more holistic and integrated approach to global development, but it also recognises that health cannot be achieved independently from other global issues. The eradication of poverty, gender equality, improved education and the need for partnerships, peace and strong institutions are just a few of the SDGs that have clear implications for health. However, this interconnectedness presents a number of unique
challenges for the field of HPSR. A selection of these challenges are summarized here.

**Challenge 1: Unified Goals vs. Local Priorities**

Agenda 2030 states that “the Sustainable Development Goals and targets are integrated and indivisible, global in nature and universally applicable, taking into account different national realities, capacities and levels of development and respecting national policies and priorities” (UN 2015, p.13). This integrated and indivisible nature has resulted in no less than 67 indicators related to health (SDSN 2015). While provision has been made for national realities, it is unlikely that all of these indicators will overlap with the current health system priorities of many countries (Thomas et al. 2016). This can result in confusion when setting the health policy agenda and potentially establish unnecessary competition for limited resources. This brings into question whether global agendas are indeed helpful or whether they upset national priorities.

The field of HPSR has recognised this challenge and is leading research efforts to capacitate institutions in the global South so that research is locally led and relevant, addresses local concerns and priorities and considers local value systems, realities and constraints. However, the challenge remains due to the majority of funding and decision-making for HPSR originating in the global North. This limits the ability of local health systems researchers to establish independent priorities and meet locally identified needs. It also reduces the leadership space for independent decision-making from a southern perspective and maintains North-South power imbalances. The challenge for HPSR as a field will be to navigate the gaps between local and global health agendas, including funders’ priorities, so that unified goals can be found and competing priorities can be aligned.

**Challenge 2: Disciplinary Positioning and Boundaries**

Another important challenge to HPSR effectiveness is its current position as a sub-discipline of Public Health in many academic and research institutions and in international development funding circles. HPSR researchers and leaders in the field have made significant efforts towards broadening HPSR research and practice so that qualitative and embedded research is increasingly used. However, the continued dominance of clinical perspectives and demand for quantitative-heavy evidence by funders and journals limits the opportunities for research outside the ideological and methodological confines of the medical field (Daniels et al. 2016).

This is significant not only because it gives rise to imbalances of power between stakeholders from different disciplines, but also because it excludes less quantifiable data. These issues undermine the capacity of the health system to be responsive to social values, weakening trust in the system and
ultimately negatively impacting health outcomes. The challenge is thus to demonstrate and advocate for recognition of rigour in HPSR studies in a context that defines robust studies by their adherence to traditional clinical guidelines for sample size, causal models, and statistical analysis. This is particularly relevant in the context of the SDGs, as the indicators and goals are largely epidemiological or economic in nature, with a quantitative focus. Key HPSR terms including equity, responsiveness, people-centered, and resilience are nowhere to be found in the ostensibly systems-focused goals. The slow pace of change in creating strong, responsive health systems will continue as long as systems are considered secondary to traditional public health priorities and as long as narrow clinical evaluations are used to assess complex, adaptive systems.

The influence of the medical discipline on HPSR impacts the ways in which students and practitioners of HPSR experience and understand the field. Recent developments in HPSR theory have emphasised the importance of interdisciplinary teaching and practice to a robust field (Sheikh et al. 2011). However, the subsumption of most global HPSR training programmes under schools of Public Health and Health Sciences has constrained the space for a significant broadening of epistemological perspectives. Commonly, HPSR departments are nested within a University’s School of Public Health and often physically located on Health Sciences campuses. Accordingly, student and young researchers’ understandings of HPSR are shaped by this context and clinical orientation, further limiting the scope for innovative and transdisciplinary HPSR teaching and practice.

Furthermore, HPSR must walk a fine line between advocating for its relevance in an industry dominated by clinical perspectives while trying not to build artificial boundaries of practice. The vertical and disease-focused nature of much health research has made carving out space for - and defining what HPSR actually includes - a considerable challenge. While the rising number of HPSR training programmes, national and local groups, global symposia, and academic journals are certainly cause for celebration, the changing profile of the HPSR field must also serve as a caution against over-definition.

In creating a space that uniquely belongs to HPSR researchers, we must not ignore the applications of HPSR perspectives, approaches, and ethics to other fields of research and other instances of engagement with the health system. For example, though whole-system research avoids focusing too narrowly on a single disease, HPSR still has implications for, and a place in, disease-focused research. Thus, while the HPSR community, led by the Alliance, must continue to advocate for HPSR funding and relevance, its individual members should build relationships with colleagues in other departments and institutions that allow a whole-system perspective to infuse even the most rigidly vertical programming.
Challenge 3: Need for Theory

The interdisciplinary nature of HPSR also entails a need for strong theory that provides a foundation for researchers from varied disciplines to understand and investigate challenges in complex adaptive health systems. A variety of factors interact to discourage theory-centric research. These include outcomes-focused funding and donor priorities, well-intentioned attempts to ensure that research responds to the pragmatic needs of health system stakeholders, and a widespread desire to advocate for the immediate relevance and rigour of HPSR in a crowded global health field. Paradoxically, the current paucity of theory development and application is a significant challenge to each of these factors: robust intervention logic models require solid theories of change; empirical studies are often meaningless when detached from theories that situate them within broader models of health system interactions; and the HPSR field will become a shallow one unless anchored by theory developed with a systems perspective.

This challenge is further exacerbated by its interconnectedness with the power imbalances and disciplinary limitations previously discussed. The subsumption of HPSR within Public Health confers requirements on HPSR courses that emphasise empirical studies over theoretical ones, including in Master’s Degree theses and PhD dissertations. Additionally, the predominance of Northern paradigms and perspectives in HPSR weakens the applicability of existing theory to Southern systems and risks the continued development of theory that is incomplete because it fails to account for local values and social structures.

As Sheikh et. al (2011) argue, HPSR that addresses more fundamental, exploratory, and explanatory questions of health policies and systems within social and political contexts is central to meeting long-term development goals. It is also the basis for a body of reference knowledge and, most critically, a firm theoretical platform on which future researchers can build. Accordingly, we argue that the dominant HPSR emphasis on addressing operational needs should be complemented with initiatives aimed at developing and testing contextualized theories.

Challenge 4: Social Responsiveness and Accountability

The final challenge for HPSR is closely tied to the goals of equity and inclusivity in health systems. Equity and inclusivity remain key issues for achieving the SDGs and health systems strengthening and development (UN 2015; AHPHR 2016). However, the role of HPSR in fostering these has so far been underplayed. The use of Participatory Action Research and Realist Evaluation have long been identified as two approaches to building inclusivity and increasing the social responsiveness and accountability of research (Chambers 1995). Not only do these approaches embrace the contexts in which research occurs, but they welcome the complexity that is rife in health systems. Furthermore, they promote shared ownership of the research process in the hope of bringing about transformative, uplifting and empowering
However, developing the capacity of health systems researchers to ethically and effectively conduct such research remains a challenging endeavor for a number of reasons. Firstly, the theoretical foundations for ethical HPSR are lacking. While the standard ethical guidelines for clinical fields form a basic point of reference, they are by no means sufficient. The real-world, embedded nature of health systems research calls for ethical practice that goes above and beyond the need for beneficence and nonmaleficence. Issues of autonomy in the context of long term research partnerships with the health system and the social justice implications of HPSR work raises the need for trust, collaboration and negotiation to a level not catered for by current ethical procedures (Gilson 2012; Olivier et al. 2016). There is an urgent need to develop and test relevant HPSR-specific ethical considerations if the field is to reach its true potential.

Secondly, while the SDGs create new responsibilities for many countries, they fail to reflect the extent to which donor funding streams and development programmes guide the actions of national governments, or to create responsibilities for more ethical and reflexive aid. If these organisations continue to disburse aid in a vertical manner, ignoring the need to strengthen health systems by strengthening the societies that form them, how can LMIC countries who rely heavily on these organisations achieve the SDGs? Moreover, how can HPSR researchers sustainability conduct their research if resources continue to sway research priorities towards clinical findings? It is imperative that development and donor organisations are viewed as part of the global health system, with full recognition that their actions may constrain the potential for change. Perhaps the field’s biggest challenge yet is to recognize the role of development agencies, aid organisations and United Nation bodies in getting us to where we are now and to explore how this can be changed.

The challenges discussed in this paper are the expressions of a need for a paradigm shift in the field of HPSR. The imbalances of power, hierarchies of epistemologies, and inequities of opportunity discussed are historically rooted and socially embedded, constituting, albeit it unconsciously, part of the identity of the HPSR community. The recent student protests in South Africa demanding decolonisation of tertiary institutions, which shut down the higher education sector for a number of weeks, indicate a growing, broad based recognition of the imbalances in power that form the foundation of many societies and communities, including HPSR. However, the responses of academic institutions and society more broadly also reveal the extent to which calls for such a paradigm shift are experienced by many as traumatic, disruptive, discomforting and often violent. In calling attention to the ways in which such power imbalances shape our own community of practice we must remain sensitive to the ways in which such calls are experienced by many. In responding to the challenges discussed in this paper, the HPSR
community should be aware of the risk of increasing discord when disrupting the status quo. Retaining the strength of HPSR will require leaders in the field to model positive responses and demonstrate a commitment to social justice that embraces competing realities and perspectives in their practice of HSPR.

**Solutions**

The interconnected nature of Agenda 2030 has created a significant opportunity for HPSR to take a leading role in health systems research and development. Its multidisciplinary nature places it in a unique position to build a bridge between traditionally vertical fields of research. With branches in biomedical and social health sciences, economics, politics and management studies, it is the only field currently prepared to embark on 15 years of complex, interrelated health research. This places it in a strong position to influence key health system stakeholders, from global organisations and multilateral funders to local ministers of health, policy decision makers and clinicians. The following describes potential innovations and approaches leaders in the field should employ to ensure the increased production and use of HPSR by all stakeholders.

**Advocating for Systems-Oriented Funding and Evaluation Model**

Current models for funding and evaluating health system interventions fail to account for the challenges inherent in measuring and defining strong health systems. The desire to ensure accountability on the part of donors, recipients, and implementing partners has given rise to a system that primarily measures the impact of aid by quantitative indicators, with further funding contingent on meeting pre-determined targets. These models must be reoriented to incorporate contextual factors and indicators grounded in the core values of HPSR to effectively address the challenges outlined above and move the field forward.

One of the challenges for donors and other international actors in adopting a systems perspective is the perceived necessity for measuring discrete results and outputs. However, at least some of the indicators of a strong, socially responsive health system would be difficult to measure quantitatively. This is because the value of health systems exceeds health gains - a good health system is not simply one that reduces morbidity and mortality. Rather the goals of the health system should be taken to include equity in the distribution of health and in protection from the financial costs of illness, the promotion of dignity and of wellbeing (defined in a culturally appropriate manner), as well as responsiveness to the expectations of the population it serves (Gilson 2012). Additionally, because health systems (as complex, resilient social systems) change slowly the effects of a systems strengthening intervention might only become clear 20 years after the intervention itself. This pace of change is incompatible with the 3-5 year funding cycles that
form the foundation of donor aid. There is thus a need to advocate for long-term funding cycles that allow implementing partners to demonstrate the long-term effects of systems strengthening interventions.

In 1999, the WHO released a series of papers intended to support an overall measure of health systems performance, one that would allow for inter-system comparisons. The first of these papers by Murray and Frenk (1999) identifies three main goals of the health system: health, responsiveness, and fairness of financing. The responsiveness goal entails that the health system should be responsive to the legitimate expectations of the population for the “non-health improving” dimensions of the system. As such, responsiveness could be assumed to include the extent to which the health system embodies and reflects social values. For example, these value-based decisions are apparent in financing mechanisms (who pays more, who is exempt from payment), inclusion criteria (who is worthy of what level of care, at what cost, who is excluded from care altogether) and benefit packages (is psycho-social support included in the benefit package, is curative care prioritised over health promotion?). It is in these decisions that a health system can either embody or ignore the values of those it serves. In practice, however, responsiveness is assessed using indicators that reflect the extent to which health services are delivered in a way that is consistent with the immediate interests of individual patients. This potential to explicate the social value of health systems is lost to the desire to ensure a quantifiable measure of health systems performance.

This case is demonstrative of what is missed when measures of value are strictly quantitative. It also highlights the challenges of developing indicators for health systems strengthening. While useful to demonstrate certain aspects of a strong health system, epidemiological and economic indicators, such as those that make up the SDG directly, fail to fully capture the value of health systems. Further research is required to explore the potential for developing indicators of strong health systems as value-based social institutions. This work will be necessarily trans-disciplinary, integrating theoretical frameworks and epistemological paradigms from a range of established fields, including politics, sociology, philosophy and management sciences. As it has already made great strides in bridging disciplinary boundaries, the Alliance is well-placed to drive these solutions. This could be done through funding for theory-building research, increasing the visibility of this kind of research in affiliated publications and conferences, and advocating for the inclusion of social scientists and theorists in industry symposiums, panels and committees.

However, this work will also necessitate a recommitment to the system-perspective, and a re-emphasis of the importance of contextual understanding for health systems analysis. If HPSR is to explicate the social nature of health systems with academic rigour, it will be necessary to re-emphasize the context-specific nature of HPSR. Recognising that health systems are social systems, influenced by broader social, political, cultural, and economic forces, rigorous HPSR should entail that findings are reported alongside detailed
contextual descriptions of the society in which it is embedded. Attempts to do so, however, are commonly constrained by academic publication formats that give minimal space for background and context, in favour of results and conclusions - a symptom, perhaps of the influence of public health on HPSR. As such, in lieu of a publication that accommodates such discussions, the Alliance should consider publishing 'context papers', alongside standard HPSR papers published elsewhere. In addition to augmenting individual publications, this would serve to create a databank of deep contextual knowledge that would support more rigorous HPSR going forward.

Elevating the Southern Perspective

With the global focus of development on systems strengthening, there is an increased opportunity to leverage HPSR to enhance policy decisions and guide implementation. First, however, there needs to be a conscious awareness of the power and potential of HPSR to stimulate relevant change, as well as a recognition and redress of the current constructs that limit such influence.

A critical starting point is increasing the capacity of Southern institutions and researchers to conduct and apply contextually relevant HPSR. While programmes aimed at improving research capacity in LMICs exist, a significant number of these are structured as discrete postgraduate training opportunities, focused largely on biomedical research, or are dominated by solutions developed through a Northern perspective. These programmes run the risk of undermining institutional systems and capacity, while also producing less relevant or influential findings (Edwards, Kaseje and Kahwa 2016; Adriansen 2016). Instead, Southern universities and practitioners should be empowered to develop the research skills and critical independence to produce knowledge, in a sustained and systematic way, that responds to societal needs and local realities.

One practical solution is to redirect research funds to the South. Currently, only 10% of worldwide resources for healthcare research is granted to those countries where 90% of preventable deaths occur (Edwards, Kaseje and Kahwa 2016). Increasing the proportion of funds allocated to Southern-led research inherently creates opportunities to build capacity. Channeling funds through existing national programmes and encouraging co-investments from governments will also increase the effectiveness of investments, facilitate social contracts between the research and society, and ensure alignment with national priorities such that findings are translated into action (Hasnida et al. 2017).

Mentorship programmes between senior and junior researchers are another approach to increasing and sustaining capacity. A mentor can provide guidance and support in conducting research, but also inspire new professionals on the value of HPSR firsthand. Mentorships can be encouraged locally, nationally or
international and are based on the premise that strong networks foster development and enhance potential. Emerging Voices in Global Health and the Junior Public Health Association of South Africa are just two examples of such programmes. However, further development of these programmes within and between LMIC institutions and researchers is essential if HPSR is to reach full potential.

Ultimately, however, a shift in the model for research capacity building is also needed. For one, international collaborations should look beyond simply producing knowledge and training individuals. Instead, commitments should also be made towards strengthening institutional capacities for generating and utilising knowledge. Secondly, capacity building initiatives should be mindful of creating or intensifying a South-North dependence – whether it be through funding, technology, or the propagation of research concepts. This will be important in ensuring that practices and perspectives rooted in the South are not neglected or excluded from contemporary understandings of HPSR. Finally, a broader ‘framework’ for evaluating research capacity building activities should be employed such that contextual relevance and application of findings are considered alongside process and outcome indicators. This will help to give Southern partners a stronger voice in determining research priorities.

Empirical studies have consistently shown that health research is best utilised when it is aligned with local needs, embedded in a local infrastructure to facilitate use, and led by local researchers who are able to help translate results into local actions (Hasnida et al. 2017). Accordingly, capacitating Southern health systems actors to generate and apply HPSR is essential to advancing the use of HPSR and achieving Agenda 2030.

Leveraging Partnerships and People

HSPR functions at the intersection between health and other systems (AHPSR 2016). As such, it is able to facilitate partnerships with a diverse range of stakeholders both in and outside the health system. These partnerships are critical to health systems strengthening, but require significant efforts in building trust (Gilson 2012; WHO 2007). Developing and maintaining flexible channels of communication, openness and ethical sharing of information are three strategies that can lay the foundation for trusting relationships (Olivier et al. 2016; Robson 2002). HPSR researchers should do well to employ these strategies in their dealings with all health system stakeholders, remembering that trust may take years to build, but only a second to lose.

Cross-country learning networks, such as the Network on Equity in Health in Southern and Eastern Africa (EQUINET) and the Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA), the latter consisting of 11 African and European University-Based Groups, are of key importance in fostering
partnerships for exchanging perspectives and experiences across boundaries. These deliberate networks have resulted in inculcating greater global leadership for health equity, stronger educational programmes, and enhanced linkages between policy makers and health systems actors (Sheikh et al. 2016).

The Collaborative for Health Systems Analysis and Innovation’s (CHESAI) Journal Club is an exemplar of leveraging the power of partnerships and people. The Journal Club brings researchers, managers, and policymakers together to review and discuss current research papers. It has come to serve as a forum for debate and reflection, for practical collaboration and coproduction of knowledge, and for facilitating connections across a range of health system actors (Sheikh et al. 2016; Lembani et al. 2016). The Journal Club is an innovative platform for building personal and lasting relationships and for translating research into action. Efforts to increase Southern-led research and practice should not occur in isolation, but also nurture the development of similar networks and discussion fora to drive shared learning and amplify collective Southern voices.

The need for trust, communication and partnerships demonstrates the central role of people in health systems and HPSR. People in power and, especially those who are not, should all be included in moving the field of HPSR forward. The Alliance is well-placed to play a central role in corralling broad and inclusive efforts towards this end.

**Conclusion**

In 1990, the Commission on Health Research for Development (CHRD) stated that “developing countries need stronger scientific and institutional capacity to address problems unique to their circumstances, but sufficient investment is not being made to build...their health research capacity” (p. xvii). The Commission went on to note that health policy research, social sciences and management studies were particularly weak and ill-supported, and that research support focused disproportionately on human reproduction and HIV/AIDS (CHRD 1990). This characterisation of the state of affairs remains surprisingly fitting to the current HPSR context. It is clear that while some progress has been made, much remains to be done.

Pressing challenges include navigating the gaps between global and local health agendas, conducting trans-disciplinary HPSR while maintaining close institutional ties to medical disciplines, developing and furthering theory-building for HPSR, and overcoming these challenges in a way that is reflexive and demonstrates accountability. As these, and other, challenges continue to evolve, the Alliance’s role will be to provide leadership and direction in line with the objectives and principles that have formed the foundation of its important contributions thus far. Possible solutions include developing and advocating for systems-oriented funding and evaluation models, developing systems-oriented indicators of health
systems change, increasing the scope for attention to context in HPSR publications, increasing the capacity of Southern research institutions to teach and practice HPSR from Southern perspectives, and innovative models for collaboration and joint learning. There is much potential for improvement, and the Alliance remains uniquely placed to implement these solutions. More than ever, the Alliance and Health Systems Global’s position as a forum for the HPSR community will be crucial to navigating challenges around power imbalances and partnerships, both within the established HPSR community and with those outside it.
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