

Implementation research and delivery science

In public health research, the focus has traditionally been on descriptive and analytic epidemiological research (“what”, “why”, “where,” and “who”). Less attention has been given, particularly in low-income countries, to “how” interventions do or do not work in the “real world”, given the involvement of different actors, the context in which implementation occurs, and the factors that influence implementation. Future Health Systems (FHS) has been at the forefront in the exploration, application and growth of implementation research (IR).

Background

Whilst work has grown around policy development and research into identifying interventions, it has been frustrated by failures to implement interventions at scale to reach those in need. David Peters of Johns Hopkins University (JHU) and FHS started work on implementation research and delivery science (IRDS) while at the World Bank (WB) in the mid-2000s. In 2009, a [WB book focusing on problems with implementation service delivery](#) was published. Peters conducted systematic reviews around interventions to improve implementation, country case studies on how to address different implementation problems, large cohort analyses, and reviews of WB projects.

Simultaneously, he produced work for the World Health Organization (WHO) on innovations that improve service delivery, including community engagement and empowerment, highlighting the problems with implementation and how to overcome them, especially for disadvantaged groups.

This research indicated that while many interventions work, “how” they are implemented is more important. Engaging stakeholders, using data, having intention, and closely following up made a difference. This all led to thinking around complex adaptive systems (CAS) and doing research more relevant to improving implementation. This, in turn, informed the FHS Phase Two theme selection recognising the need to address both supply and demand in health systems, which the WHO Building Blocks was lacking.

Many agencies were turning in this direction, trying tests of concepts (e.g. PEPFAR), but taking diverse and separate paths. In June 2010, USAID hosted a conference on Implementation Problems and Scaling-up, which used the WB book as an

organizing framework. Peters and others also delivered presentations based on the WB book. This prompted the WHO Alliance for Health Policy and Systems Research (AHPSR) to request Peters and JHU colleagues to define the field of IR.

They examined and amalgamated the historical threads (e.g. clinical epidemiology; operations research; policy evaluation) to come up with one approach. This led to a [practical guide for using implementation research in health](#) and a [British Medical Journal paper](#) in 2013, which were released around the time of the 2012 Global Symposium on Health Systems Research (HSR) in Beijing.

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After Beijing, effort was made to organise like-minded people and organisations (e.g. [USAID TRAction Project](#), AHPSR, etc.). Many consultations were carried out and products generated to highlight the diversity of methods, places and

organisations working together doing IR. This led to the [Cape Town Statement on Implementation Research and Delivery Science](#) (released at the 2014 Global Symposium on HSR, with over 200 signatories to date), capturing multiple perspectives, and advocating for the IR field, how to do it, what needs to change around stakeholder audiences (e.g. incentives in academia), and what is promising.

What changes took place?

The IR field is growing and continuing to gain traction. Funding agencies are reorienting to implementer- and policymaker-led research. For example, PEPFAR has changed its goals highlighting the role of implementation. AHPSR released a call for implementer-led research, receiving 200 applications. Gavi shifted from a standard strategy to country-specific strategies, led by implementers

and policymakers. Requests for IR are being made to development partners by decision-makers in LMICs (e.g. the Pan-American Health Organization is working with Ministries of Health on IR).

How did FHS contribute to the change(s)?

FHS and work on IRDS has involved a number of the same people, with FHS' biggest influence being in the ways of thinking that come from doing research. In particular, FHS encouraged: stakeholders to recognise and understand the need for continuous use of data for transparency and accountability; notions of intention that to serve poor people, you need to be explicit about your aims and measure it; recognition of CAS and the need to change because of understanding context and stakeholders; and recognition that issues of power and influence are important because they affect implementation.

FHS' conceptual and synthesis work on markets and informal providers has also been influential. For example, the health markets work led recognition of formal and informal organisations' influence on supply and demand, overcoming market failures and sustainability, and work using the 'develop-distort-dilemma' framework. These are all about implementation and how it happens.

Many FHS projects are designed to work with and influence national audiences. In Uganda, FHS work with *boda boda* drivers using quasi-experimental design has received recognition. In China, demonstrating the combination of medical

assistance and health insurance has been influential in work with Chinese policymakers who have been receptive to CAS. In India, the State Government of West Bengal, based on FHS's work highlighting the extent of the use of Informal Health Providers (IHPs) for child health care in the Sundarbans delta region, has requested that FHS carry out IR on capacity building and mainstreaming of IHPs to inform the pilot and scale-up of a Department of Health and Family Welfare backed project.

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What next?

A Lancet series on IRDS that brings together diverse groups is currently in development. There are still questions around 'what is research' and if it applies to IR. An IR project can be about quality improvement, but that has implications for independence. Theories and methods are evolving, and more research is being sponsored and carried out.

There are different opportunities to shape the field but funding is variable. Funding for IR often comes from programme funds originally destined for M&E. Funding for the field is still relatively small but growing, partly from policymaker demand. DFID is capable of doing both (research and programmes) because it has limited research funds, but considerable programmatic funds. However, transactions exist between research and programme actors/agencies and bridges also need to be built to beneficiaries.

There is not often a chance to contribute to field building at this level: changing behaviour of programme implementers and improving understanding through research to develop more sophisticated thinking about health systems and how they work.

CREDITS

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