

COMMENT

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Building Health Policy and Systems Research (HPSR) capacity in India: Reflections from the India HPSR fellowship program (2020–2023)

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Abstract

Building capacity for Health Policy and Systems Research (HPSR) is critical for advancing the field in lower- and middle-income countries (LMICs). The India HPSR fellowship program is a home-grown capacity-building initiative, anchored at the Health Systems Transformation Platform (HSTP), New Delhi, and developed in collaboration with a network of institutes in India and abroad. In this practice-oriented commentary, we provide an overview of the fellowship program and critically reflect upon the learnings from working with three cohorts of fellows between 2020 and 2023. This commentary draws on routine program documentation (guidelines, faculty meeting reports, minutes of meetings of curricula and course development) as well as the perspectives of faculty and program managers associated with the fellowship. We have had several important learnings in the initial years of program implementation. One, it is important to iteratively modify globally available curricula and pedagogies on HPSR to suit country-specific requirements and include a strong component of ‘unlearning’ in such fellowships. Secondly, the goals of such fellowship programs need to be designed with country-specific contextual realities in mind. For instance, should publication of fellows’ work be an intended goal, then contextual deterrents to publication such as article processing fees, language barriers and work-related obligations of faculty and participants need to be addressed. Furthermore, to improve the policy translation of fellows’ work, such programs need to make broader efforts to strengthen research–policy–practice interfaces. Lastly, fellowship programs are cost-intensive, and outputs from them, such as papers or policy translation, are less immediate and less visible to donors. In the absence of these outputs, consistent funding can be a roadblock to sustaining these fellowships in LMICs. The experience of our fellowship program suggests that LMIC-led capacity-building initiatives on HPSR have the potential to influence changes in health systems and build the capacity of researchers to generate evidence for policy-making. The sharing of resources and teaching material through the fellowship can enable learning for all institutions involved. Furthermore, such initiatives can serve as a launchpad for the creation of regional and international HPSR communities of practice, with a focus on LMICs, thereby challenging epistemic injustice in teaching and learning HPSR.

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Introduction

Strong health systems are essential for improving health outcomes in populations, reducing health inequities and making progress on the Sustainable Development Goals [1, 2]. However, timely and context-sensitive evidence that is needed for strengthening policies and systems is often lacking in lower- and middle-income countries (LMICs) [3, 4]. Health Policy and Systems Research (HPSR) is a field that seeks to fill this need for contextually relevant, actionable evidence for strengthening systems and improving policy processes [5]. Beyond generating evidence sensitive to context and keeping people at the centre of change, HPSR aims to effect structural change as well as intervene upon the ‘soft’ aspects of health policies and systems. HPSR draws from multiple disciplines with an explicit commitment to social justice and equity [6]. Experiences across LMICs have demonstrated, to varying degrees, the influence of HPSR in bridging the gap between the research, policy and practice worlds [7, 8].

While HPSR as an evolving field faces many challenges, building capacity to conduct HPSR has been a key constraint globally [9, 10]. This is partly because the field is diverse and multidisciplinary, with fuzzy boundaries. Being a field of inquiry defined on the basis of solving a given health system problem, there is often a lack of standardized methodological templates for HPSR studies. Furthermore, building research capacities in LMICs has usually been helmed by actors and agencies from high-income countries (HIC). The problems with such a system of capacity-building are manifold: research-oriented courses are often costly for candidates from LMICs to enrol in, there is less contextualization of curricula and there are possible misalignments between the skills taught and the skills needed to do research in LMICs [11, 12]. Given these issues, it is clear that a field such as HPSR needs domestic LMIC-led capacity-building initiatives that are designed purposefully in consideration of national and sub-national contexts.

The India HPSR fellowship program (2020–2023) is one such home-grown effort at HPSR capacity-building. Anchored at the Health Systems Transformation Platform (HSTP) in India, it collaborates with a network of institutes across the globe. The program was designed as a platform for developing a collective understanding of HPSR contextualized to India’s needs to encourage the production of knowledge in this region. In this commentary, we present the rationale, design and functioning of the program and critically reflect upon the learnings so far. The aim of this commentary is to inspire and inform other such LMIC-led efforts at building HPSR capacity locally and regionally. “We” refers to all of us involved in

the design and implementation of the fellowship (course coordinators, advisors and faculty).

For writing this reflective essay, S.J. collated a set of documents that were produced during the course of the program (2020–2023). These documents comprised (a) program development documents (two academic committee meeting reports involving external HPSR experts), (b) curriculum and design-related documents (minutes of one advisory committee meeting, three selection committee meetings, and eleven faculty meetings and (c) implementation-related documents (one report on the fellows’ accolades and achievements during/after the fellowship and minutes of Secretariat operational meetings). S.J. and S.R. prepared a preliminary summary analysis, which was then shared with all faculty who are authors. All faculty members worked further on this, deepening and expanding on the conceptual areas in the paper. As a final step, once the paper was drafted, it was sent to two HPSR experts, one Indian and one global, for their input (Fig. 1).

The rationale for focused HPSR training in India

Indian context

Much of public health training in India currently happens in medical schools, as part of post-graduate degrees in community medicine, and largely employs a biomedical lens [13]. In the last two decades, public health schools with an interdisciplinary focus have been steadily increasing in number [14]. However, our experience suggests that rigorous training to conduct research on health policy and health systems is still sparse in both medical and public health schools in India. For instance, of approximately 500 courses on public health and management in India listed on two websites [15, 16], less than 30 explicitly mentioned having a teaching module (or sub-module) on health policy and/or health systems research. The authors of this paper have frequently noted that public health stakeholders in India, including senior policymakers, use the terms “health system” and “government health services” interchangeably. Given this, the paucity of peer-reviewed outputs from India on health policy and systems is not surprising; Rao et al. found just 314 papers discussing various aspects of health systems in India [17]. Another review noted that 90% of articles published in India between 2000 and 2010 on public health were focused on individual diseases [18], as opposed to broader topics of health systems strengthening.

Philosophy and origin

The India HPSR fellowship program began in 2020 with the intention of addressing the above-stated issues in the country. The program was conceived against the backdrop of ongoing global discussions on epistemic

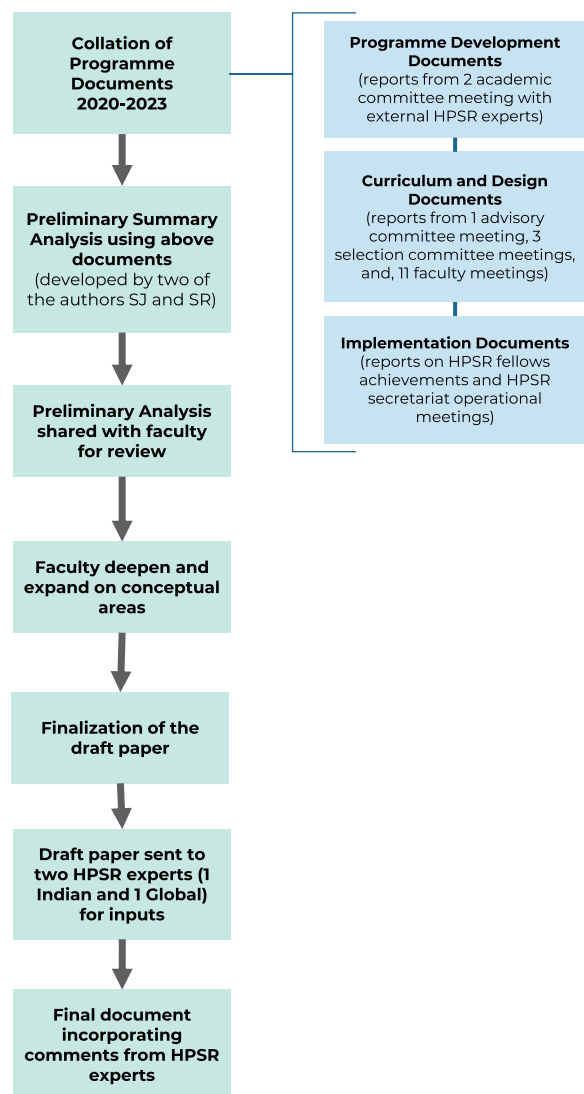


Fig. 1 Methods (with additional details provided in A.1. Supplementary File)

injustice in knowledge production [19]. It has been noted that research outputs are frequently focused on issues that are more prevalent in HICs, while research needs in LMICs remain unmet [20]. Furthermore, evidence from research often remains delinked from policy-making [21]. The India HPSR program was launched with the aim of promoting fairer knowledge practices by, firstly, strengthening ties between academicians and policy-makers in the country and, secondly, breaking hierarchies among different disciplines of researchers in the country (medical, anthropological, sociological, finance and others) to encourage research that has meaning in the real world.

The India HPSR program is anchored by the HSTP, New Delhi. It has been jointly developed by and is being delivered in collaboration with the Institute of Public Health, Bengaluru, India (IPH); Sree Chitra Thirunal Institute of Medical Sciences & Technology, Thiruvananthapuram, India (SCTIMST); Christian Medical College, Vellore, India (CMC); The George Institute for Global Health, New Delhi, India (TGI); Nossal Institute for Global Health, University of Melbourne, Australia (UOM); and the Institute of Tropical Medicine, Antwerp (ITM) (Fig. 2). The fellowship is supported by Tata Trusts, the Bill & Melinda Gates Foundation (BMGF) and Access Health International. More details about the design and implementation of the program are discussed below. We have also attached supplementary material on the processes followed prior to the initiation of the program (A.2. Overview of India HPSR Fellowship Program in Supplementary File).

Overview of the India HPSR fellowship program

The India HPSR program takes a two-level approach to capacity-building. At the individual level, the program aims to develop the capacity of researchers from different disciplinary backgrounds to conduct HPSR. At the collective level, it aims to build a network of HPSR experts across key institutions in academic, research and policy settings in the country and abroad. The fellowship program, spread over 18–24 months, uses a blended training approach and comprises of three components:

- An initial face-to-face session
- A 6-month online learning phase with five modules culminating in a synthesis workshop
- A 12-month grant for the fellow to independently conduct an HPSR study.

Figure 3 summarizes the course structure of the program.

The 5-day introductory face-to-face session was introduced in 2022 for the second cohort [due to coronavirus disease (COVID-19), this session was not conducted for the first cohort]. This introductory component gave participants an overview of the HPSR learnings to follow, helping to create a sense of community among them. The face-to-face session is followed by a 6–8-month online learning phase delivered through a dedicated learning management system. All five modules are conducted in an interactive manner and include lectures, practical exercises, online discussion forums, discussion of peer-reviewed literature, assignments and interactions with global experts. Participant-centred learning outcomes

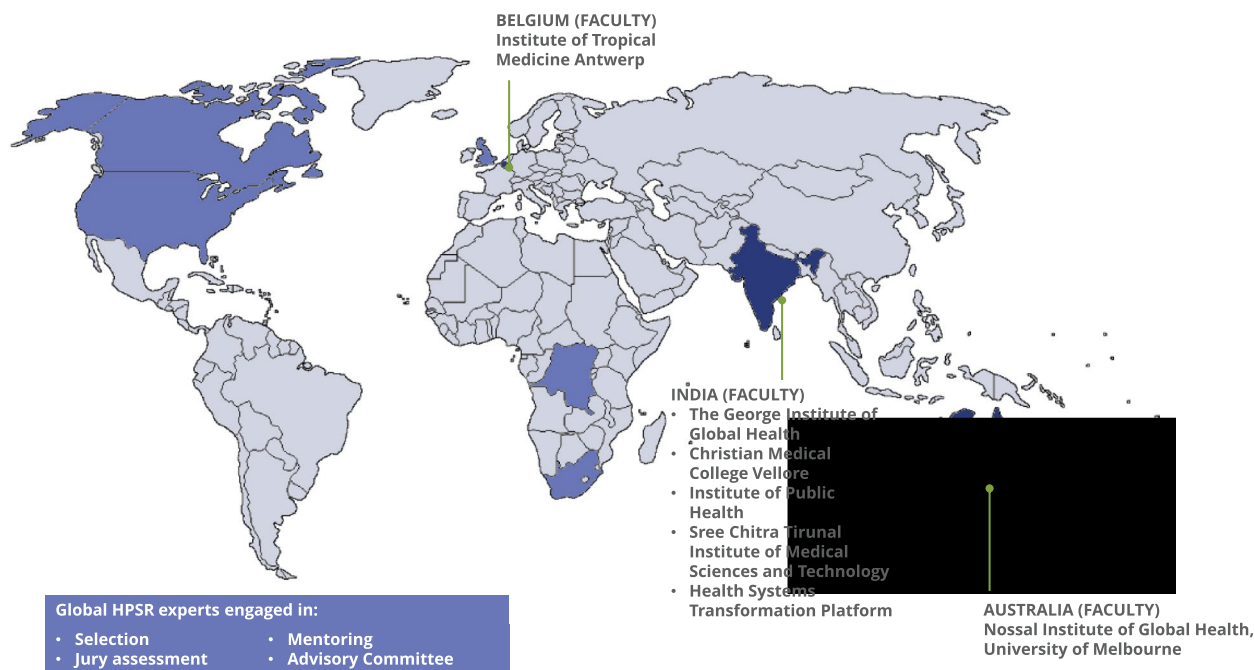


Fig. 2 The India HPSR program network

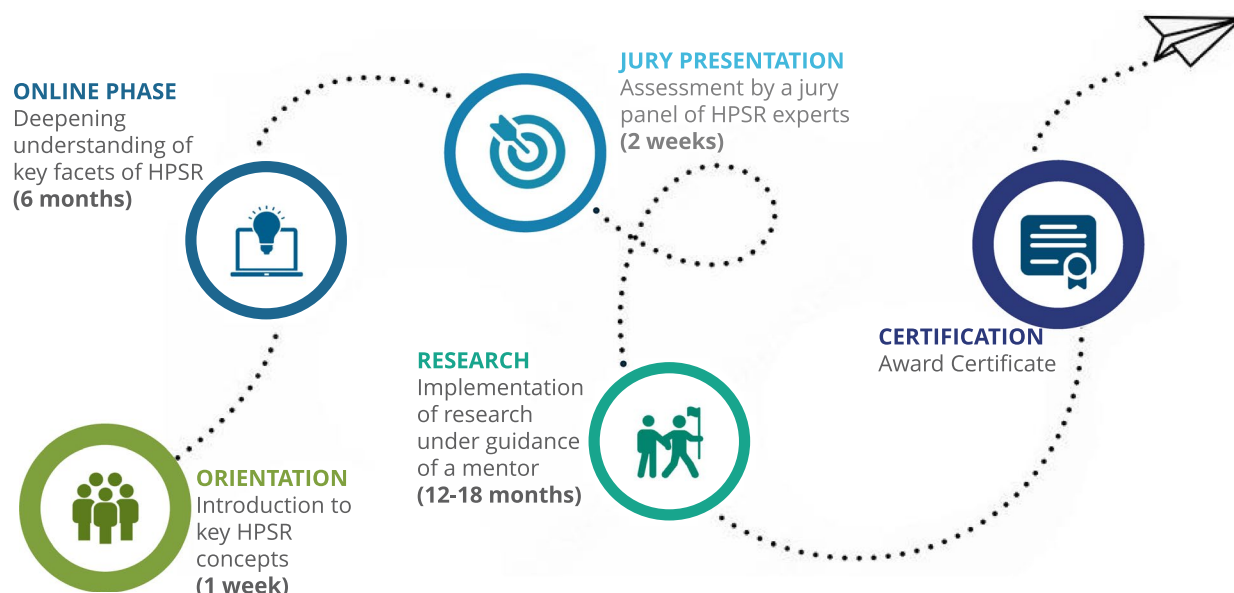


Fig. 3 India HPSR Fellowship Course structure

have been defined for all the modules (A.3. Course Curriculum in Supplementary File). Upon completion of the modules, each fellow undertakes an HPSR study independently. Before beginning their study, fellows present their proposals to a jury consisting of course faculty as well as

external HPSR specialists. Thereafter, successful candidates are awarded a fellowship research grant and paired with global HPSR mentors. At the end of 12 months, a fellow who completes their research and submits a report is certified as an HPSR fellow.

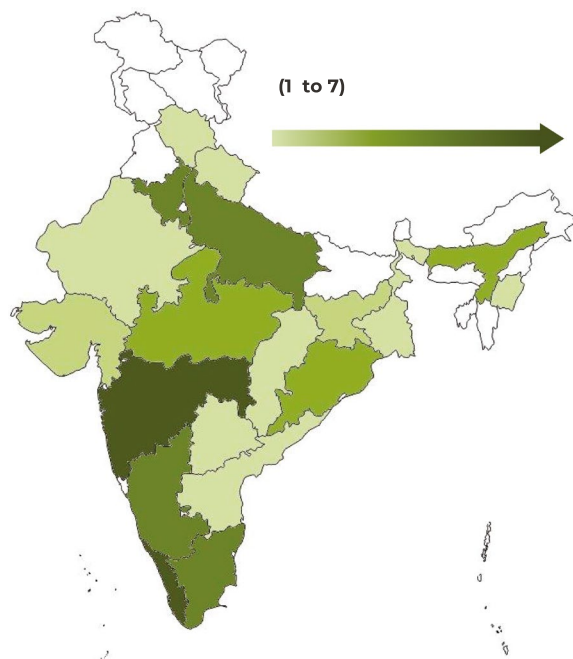


Fig. 4 Distribution of India HPSR fellows

Reflections on program design and implementation

The India HPSR fellowship program was developed with extensive input from Indian and global experts who have been instrumental in building the field of HPSR. The initial curriculum was developed following two rounds of discussion with both national and international experts in 2020 [22, 23]. The long fellowship duration (18–24 months) allowed fellows to participate at their own pace. This duration was consistent with the thinking that, while short-term courses have their place, long-term engagement and comprehensive efforts would be more useful in advancing HPSR thinking [24].

Through a carefully crafted set of criteria and a multi-round screening process, our participants have been selected from diverse backgrounds across the country (Fig. 4). India is a diverse country with several disparities in human development across and within states [25]. In the spirit of promoting fairer knowledge practices, we purposively selected candidates to ensure geographical diversity in the fellowship. We also gave preference to candidates who expressed interest in conducting contextually relevant research in tribal and remote locations that tend to be under-researched. This manner of selection led to a geographically diverse group of candidates in the program who had varying competencies and levels of exposure to research. Some of our candidates needed more support than others to complete the

course requirements. We tried our best to accommodate requests for additional online mentoring and individualized coaching for candidates who requested support.

Equal importance was placed in the program on building individual capacities and developing the potential of selected fellows to build capacities within their institutions. The idea was for these individuals to become important change agents and leaders in HPSR by adopting research and teaching approaches that they have learnt during the fellowship, within their institutions and more broadly in the Indian context. We have captured the reflections of faculty on the details of design and implementation of the program in Table 1. Figure 5 depicts demographic details of the India HPSR fellows. Figure 6 depicts the current status of the fellows' participation in the program.

Reflections on the strides made and challenges faced by the program

In this section, we critically reflect on the three initial years of the fellowship. Global thinking suggests that HPSR capacity-building efforts need to be directed not only at individuals but also at the level of organizations and systems (the collective) [26]. In line with these, we share our thoughts on the strides made as well as the challenges faced at both the individual and the collective level in the HPSR fellowship.

Faculty reflections on capacity-building efforts made at individual level

Different ways of thinking and career opportunities among participants

Box 1 is a summary of faculty reflections on “different ways of thinking” inculcated during the fellowship. Although some of these may seem self-evident, we believe these were important insights for *freshers* to HPSR in the country. Many of our participants are from institutions with strong organizational hierarchies and are exposed predominantly to positivist research paradigms. Other paradigms of research with different ontological, epistemological and methodological perspectives were new to many participants, despite their important role in building knowledge on health policies and systems. A key milestone for many participants was to be able to see health policy and/or systems ‘problems’ as more than epidemiological patterns and to embrace the complexities of health policies and systems, as well as to be able to critically reflect on health policies and systems. It took some time for participants to see ‘problems’ as more than just epidemiological concerns, to accept the complexities of HPSR, and to actively engage in reflection.

Table 1 Reflections on program design and implementation [C1 - Cohort 1 (2021); C2- Cohort 2 (2022); C3 -Cohort 3 (2023)]

Areas	Description	Current operational status	Author reflections
Fellows' selection and profile	<p>We launch an annual call for applications. Candidates submit a Statement of Purpose and a research concept note.</p> <p>First stage: Applications are screened on the basis of eligibility criteria.</p> <p>Second stage: Each application is reviewed independently by two reviewers. Candidates are ranked on the basis of scores.</p> <p>Third stage: Shortlisted candidates are asked to discuss their research question with important stakeholders, following which they are interviewed by the faculty for the final decision.</p> <p>Final stage: The selection committee selects 20 candidates.</p>	<p>Three cohorts have been trained so far. Selection of the fourth cohort of fellows is underway.</p>	<p>Selection is weighed in favour of candidates from states with poor health indicators in India.</p> <p>By Cohort 2, we realized that prospective candidates had limited understanding of health policy and systems issues. Therefore, we mandated that applicants in the third cohort interact with different health system and policy stakeholders before framing their research question in their fellowship application. This interaction was reported as an eye opener by many candidates.</p>
Online course	<p>Medium of instruction: English</p> <p>Course structure: A blended training program which includes weekly online lectures by HPSR experts. This is interspersed with exercises and assignments that were graded. At the end of the online phase, there was one more face-to-face interaction, where the fellows could clarify and fine-tune their proposals with the help of peers.</p>	<p>The online phase has evolved considerably over 3 years.</p> <p>Flipped classroom approaches were attempted but were not very successful, as the candidates prepared inadequately for these classes.</p>	<p>Some participants found it difficult to attend online lectures due to conflicts with their work schedule. Nevertheless, recordings were made available on an online platform for fellows to access the classes at their own convenience. Despite the fact that the majority of the fellows were stationed in tier-2 cities, none of them faced internet access issues.</p> <p>Although every attempt was made to provide feedback on assignments and exercises as soon as possible, inadvertent delays occurred due to two main reasons. First, many of the fellows submitted their assignments beyond the deadlines; hence correction was further delayed due to faculty's time conflicts.</p>
Course content	<p>Online modules: 5 online modules covering health systems, health policy, HPSR research questions, research methods and writing HPSR proposals.</p> <p>Workshops: 2 contact sessions – an inaugural session for introduction to HPSR concepts and a synthesis session upon completion of online modules.</p> <p>Jury presentations: Fellows present their proposals to a mixed jury comprising faculty and other experts.</p> <p>Mentorship and implementation phase: 12–18 months' implementation period with mentorship component.</p>	<p>C1 – Comprehensive curriculum designed.</p> <p>C2 – Modified curriculum with addition of Indian case studies.</p> <p>C3 – Modified curriculum with increased focus on the HPSR project to be done by fellows.</p> <p>The curriculum was modified for each cohort on the basis of inputs from fellows, faculty and external auditors. In Cohort C3, the research problem and research questions were identified in the initial face-to-face session itself, and then, the fellows were encouraged to follow this golden thread through the rest of the classes. Many of the research questions evolved over the online phase.</p>	<p>The course content has evolved to reflect a more applied paradigm in comparison with the original curriculum. The present course emphasizes more on the application of a few theories in real-world research settings. So, at present, assignments have shifted to 'describe the health system in detail in your research site' or 'identify at least three HPS problems in your research site and then develop the appropriate HPS research question'.</p> <p>Another challenge was to balance the learning of qualitative and quantitative methods in the course. We did not give in-depth focus on quantitative methods such as surveys and statistical analysis in this fellowship.</p>

Table 1 (continued)

Areas	Description	Current operational status	Author reflections
Conduct HPSR study.	Conducted over 12–18 months in which fellows are paired with a mentor to complete their HPSR study.	C1 – 14 (of 20) have been certified as an India HPSR fellow. C2 – 12 (of 20) candidates have conducted their research studies. C3 – 14 (of 20) candidates will conduct their research studies.	The time for completing the study was increased for the first two cohorts since fellows found it challenging to complete in 12 months. Some of the reasons for the delay were (1) delayed grant disbursement, (2) miscalculation of the time required for permissions (ethics committee, government, institutional) by fellows, and (3) underestimation of the time for doing the analysis. Almost all fellows were doing this study alongside a full-time job, and they found it difficult to set aside dedicated time for the HPSR study.
Fellows' HPSR topics (C1, 2, and 3) (A.4. <i>India HPSR fellows' research topics in Supplementary File</i>)	Fellows proposed potential research problems to study as part of the HPSR project.	Proposed topics evolve during the course and are finalized before jury presentations.	Participants from C1 and C2 struggled to define their research questions for the HPSR study. Learning from this experience, participants of C3 were encouraged to think of their HPSR study early on in the fellowship. They were also encouraged to talk to policymakers and other relevant stakeholders to come up with more locally relevant research questions.

(C1, C2, C3) (n=60)

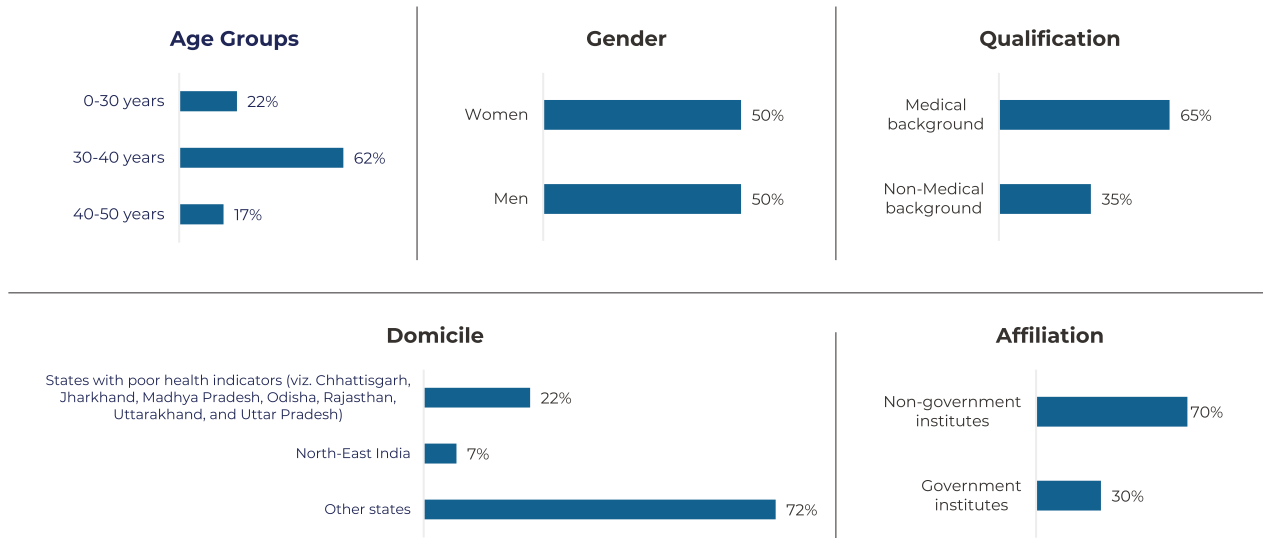


Fig. 5 Demographics of India HPSR fellows

(n=60)

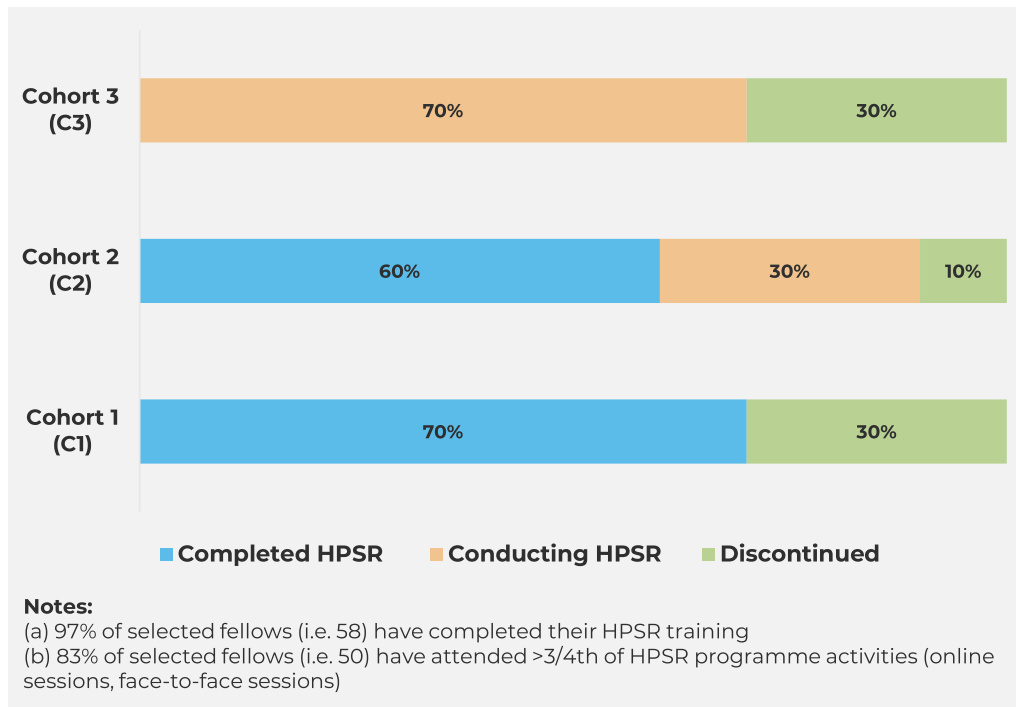


Fig. 6 Status of India HPSR fellowship cohorts

Box 1. Different ways of thinking and unlearning during the fellowship (faculty perspectives)

- In HPSR, it is okay to be uncertain and be comfortable with the idea that we do not have all the answers.
- There is not a 'single truth', and there can be multiple interpretations of the same issue. (This was particularly difficult to unlearn for those trained to seek an objective 'reality').
- A "problem" in HPSR does not mean a disease or ailment. These can be system-level and policy-level problems.
- Different course facilitators view the world through the lenses they prefer, depending on their disciplines. It is acceptable to have different opinions.
- Everyone brings their core beliefs and principles into their research practice. This needs to be made explicit.
- Developing 'soft skills' to do research is as important as mastering technical frameworks.
- Context-specific findings are useful, especially if you want to change a local policy or practice. Context is important, and the findings of research need not be applicable to all situations.

We believe that a great deal of 'unlearning' happened along with 'learning' during the fellowship. Unlearning, as noted in literature, is critical to health system improvements [27], and a recent case has been made in support of 'unlearning health systems' [28]. Yet, unlearning is not easy to bring about, at either an individual or systems level, and often involves a deliberate process of reflection in which old ways of thinking/acting are questioned, challenged and adapted. Additionally, unlearning also very often involves an external catalyst and can be associated with deeper emotions such as fear and confusion [29]. In this case, the HPSR fellowship program can be thought of as an external catalyst to the unlearning process. In the training program, each of the five online modules has one unstructured session. We believe that these unstructured sessions serve as an important space for fellows to voice their ideas on both theory and practice of HPSR. For instance, in one of the sessions on health policy, fellows discussed how they had unlearned the idea of policies as 'objective documents' and embraced the notion that health policies were political. In Cohort 3's face-to-face session, fellows questioned deeply rooted beliefs they had on the hegemony of 'context-free' research. In addition to these unstructured sessions, we also had an online forum wherein fellows could pose questions or comments, with other fellows and faculty engaging with these thoughts.

This forum provided a safe space outside of the routine workplace environments for deliberative discussions.

Many fellows shared with faculty their achievements during and after the HPSR fellowship course. These have included getting admissions into doctoral programs related to policy and systems or writing research grants very differently from before (*A.5. Fellows' Achievements in Supplementary File*). While these achievements cannot be attributed only to learning or unlearning processes in the fellowship, fellows have many times indicated that reflective interactions during the fellowship have bolstered their confidence to think differently.

Research experiences gained by participants, but challenges in defining program outputs

As part of the fellowship, participants have to independently conduct a HPSR study of one year under the guidance of a mentor. For many reasons, this phase took longer than a year for both cohorts. First, it took some time for participants to zero in on the type of research they intended to conduct, thinking through the different lenses and frameworks they had been introduced to. Second, a majority of participants working full-time jobs found it challenging to manage work responsibilities with the fellowship's commitments. Third, while we had a range of excellent Indian and global mentors, we felt that the fellows needed intense local handholding and supervision, which was missing from the fellowship design. Lastly, administrative delays led to the late disbursement of research funds, causing timelines to be further extended. Despite these challenges, we believe all our fellows have gained some experience in independently conducting an HPSR study from start to finish. Developing writing, analytical, and project management skills were abilities that participants frequently discussed with faculty as beneficial to their overall development. These reflections echo those published by other long-term HPSR fellowships as well [30].

Well-meaning donors expect rigorous peer-reviewed publications by fellows as outputs. As of today, however, this is still a work in progress. Many of the research reports submitted by participants have interesting insights and fresh perspectives on HPSR, but converting these to peer-reviewed publications could be a long journey. For one, intensive time commitment is required from both fellows and mentors for the reports to take the form of peer-reviewed academic scholarship. Furthermore, language obstacles impede publishing, as often noted in relation to scientific discourse in LMICs [31, 32]. While the majority of our fellows converse well and write in English, meeting linguistic standards required by international publications in the field is not easy for all of them.

In the fellowship, we expect fellows to produce locally relevant work. To achieve this, even the selection process emphasizes candidates discussing the relevance of the proposed research with local policy-makers. However, despite its contextual relevance, it has been a challenge to publish such work. Often, fellows struggle to present a simplified reality of their findings in a globally understood language and incorporate enough of a ‘foreign gaze’ [33] to appeal to publishers. Also, we do not know whether we should choose a set of participants (such as doctoral students) who would be more amenable to participating in publications, if indeed publications must be considered as an important program goal. In addition to all this, other structural barriers to publication in LMICs, such as exorbitant article processing charges, apply to us as well [34]. Article processing charges of international peer-reviewed journals, even with partial fee waivers, are beyond the scope of our modest fellowship grants. Given all this, we have been debating on whether it is fair to expect publications as program outputs, and if not, what some useful outputs from the fellowship would be.

Policy translation of fellow’s learnings as a program output: ongoing efforts

As other learning initiatives have pointed out, the policy impact of such programs is difficult to track or measure [26]. In our case, too, the mechanisms through which fellows’ learnings and research may translate into ‘action’ and influence policy are not well understood at present. Some of our fellows already working in public institutions are likely not just to conduct research on health systems but also to use evidence from such research or commission this type of research. With regard to a fellow’s research being used directly by policy-makers, we have had one outstanding example, where a fellow’s HPSR study recommendations to reduce nursing staff turnovers in the primary health care system were taken up by the government. However, we do recognize that, in general, so far, the HPSR studies conducted by participants have not been disseminated widely in policy circles. We also note the need to inculcate skills that enhance policy communication, now acknowledged as an essential part of the HPSR competency set [35]. The research done by fellows at present is not packaged in ways that can be used by policy-makers and practitioners. After C1 and C2, we realized that the uptake of the fellow’s research study would be challenging unless policy-makers were closely associated with the design of the fellowship project early on. Thus, in C3, fellows have been encouraged to actively build ties with local decision-makers and align research topics with their interests, so that the evidence that gets generated during the fellowship is both locally relevant and has better buy-in from policy-makers.

The expectation from the course is not to have a direct influence on policy but to build capacity to generate evidence that can influence policy. We also recognize that barriers to evidence-to-policy translation in India are not limited to our fellowship alone. Policy-makers too have limited access and capacity to engage with academic research [36], and the use of research evidence is not a norm in many settings similar to ours. Overall, supporting structures for evidence-to-policy translation are weak in LMICs [37, 38]. For research translation to be effective, we have realized the need for the fellowship consortium to work on strengthening research–policy–practice interfaces more broadly. The consortium needs to actively engage and involve policy-makers, as well as other individuals who request or use the information obtained through HPSR.

Faculty reflections on efforts made by the program at the ‘collective’ level

Building an India-centric HPSR network

In contrast to many international fellowships, the India HPSR fellowship is a ‘home-grown’ initiative. It has brought like-minded people across the globe together and built a network of people in the field. The sharing of resources and teaching material through the fellowship has contributed to learning for all institutions involved in the program.

In India, at present, there are few formal networks that connect HPS researchers across different teaching and research institutions. While initiatives in Africa such as the Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA) [39], Collaboration for Health Systems Analysis and Innovation [40] or West African Network of Emerging Leaders [41] have built collaborative networks of regional HPS researchers, such systematic, at-scale efforts have so far been missing in India. To the best of our knowledge, the Keystone Initiative has been one of the only previous efforts that explicitly focused on HPSR capacity-building and networking in India. This initiative was anchored at the Public Health Foundation of India (PHFI). It focused on developing capacities for HPSR through a 2-week participatory training course, followed by ongoing networking [42].

The above suggests that there is a strong need for building an India-centric HPSR network. For most part, in India, people working on policy and systems-related issues are based across institutions and less connected through formal collaborations. While networking initiatives such as the Implementation Research for Health Systems Strengthening (IR-HSS) do exist, ones that explicitly focus on HPSR capacity-building are largely missing at present. The Health Systems Research India

Initiative (HSRII), set up in 2010, is an e-group of researchers and practitioners with the primary objective of disseminating issues related to HPSR in India. In 2022, the India Health Systems Collaborative (IHSC) was initiated by the BMGF in an attempt to “provide an interdisciplinary platform for collaborative research” [43]. Initially, they had financed health systems research on specific topics, for example, primary health care and health care financing. However, overall, there have been fewer opportunities for sharing pedagogical content and joint mentoring, leading to a relative insularity of expertise. The India HPSR fellowship has fostered the establishment of a network of HPS researchers in the country.

Furthermore, there was recognition that a critical mass of people is needed to drive change in any given institution. This idea has been advocated by the postdoctoral fellowship on HPSR in Africa as well [30]. To achieve a critical mass, we have purposefully selected, over the three cohorts, fellows who can be change agents to build the HPSR field in their own institutions. Fellows in teaching positions have shared that the fellowship experience has helped them modify the nature of research teaching within their own institutions. Fellows across institutions too have come together through the fellowship and established informal communication channels (chat groups, email listservs and others). The challenge, in the near future, is two-fold: first, to expand and grow this network and, second, to maintain the momentum for networking generated through the fellowship experience.

On stakeholder support, recognition and resources

The first few years of the India HPSR program has had strong supporters, well-wishers and funders. The program has gained global attention and collaborations from the best in the field. In the annual Melbourne School of Population and Global Health teaching excellence awards (December 2023), the program won an award for impact in the area of engagements and partnerships.

However, to build upon these achievements, more support and resources are needed. First, there is a need to generate more resources for the fellowship program. More cohorts of fellows are needed to work towards developing a critical mass of HPSR change agents in the country. Second, and more broadly, funding is needed to create more opportunities for undertaking HPSR within India. It has been noted that the majority of funding for HPSR comes from international development partners and less from domestic or government sources [44, 45]. This manner of funding has also contributed to research that is more focused on global rather than domestic issues, with fewer avenues for translation [46]. In cognizance of these issues, we feel the need to work more closely with existing government research and training

organizations within India, such as the Indian Council for Medical Research (ICMR), the National Health Systems Resource Centre (NHSRC), and the State Health Systems Resource Centres (SHSRC).

Scope and limitations of this paper

This commentary provides an overview of the India HPSR fellowship program and captures learnings from the initial years of the program. The paper has some limitations. For one, the voices of fellows have not been explicitly considered. Secondly, we have not yet conducted a formal evaluation, which is planned for the next phase of the program. For writing this piece, we have predominantly relied on pre-existing documentation and experience-sharing by faculty and senior management. Given these limitations, the commentary’s purview is limited to introducing the program and offering some practice-oriented reflections to those keen to start similar initiatives.

The need for documenting experiential learnings from HPSR fellowships in LMICs

In recent years, there has been an increase in the number of LMIC-led HPSR papers. [47]. Developing more capacity to carry out HPSR in LMICs is crucial to sustaining this trend. LMIC-led fellowship programs have been proffered as a solution to augment existing capacity for HPSR in these settings. However, publications and documented experience-sharing from LMIC capacity-building programs on HPSR have been limited. Some learnings from the post-doctoral fellowship in Africa [30], the Health Policy Analysis fellowship for doctoral researchers in LMICs [48] and the earlier career women mentorship program in HPSR have been documented [49]. However, from the South Asian region explicitly, we did not come across published literature on HPSR capacity-building initiatives. From India, we know only of the Keystone Initiative that targeted capacity-building in HPSR for working professionals [42]. The online repository from this initiative, available online, was very useful to us as we planned our program.

Our commentary attempts to fill an important gap in documentation of capacity-building efforts from the South Asian geography. Though not an evaluation, it describes the fellowship program we developed and captures initial learnings that could be useful to others attempting capacity-building in HPSR for working professionals.

Conclusions

Early reflections from programs such as ours can offer practical guidance for others attempting comparable HPSR capacity-building programs. In keeping with

these thoughts, we summarize below some of the early learnings from the roll-out of our program:

- Fellowship programs must focus not only on giving participants a ‘flavour’ of HPSR but also enhancing people’s learning and unlearning capacities, a founding aspect of “learning health systems” [50]. If fellowship programs are to be truly multidisciplinary, then the participants of such programs must be encouraged to shed their disciplinary baggage. Unlearning becomes crucial to this process.
- There is a need to adapt pedagogies and curricula iteratively in the initial years of HPSR fellowship programs to suit national and sub-national contexts. In our case, as compared with previous iterations, the current course material is more applied and relevant to real-world research settings in India.
- The goals of fellowship programs must be aligned with contextual realities. If publications and other scholarly outputs are desired from such programs, several contextual deterrents – article processing fees, participants’ non-familiarity with the publication process, language barriers and other work commitments of faculty and participants [32, 34] – need to be addressed.
- Fellowship programs can provide a great platform to network with people, local and global, who are passionate advocates of HPSR. Other training experiences have noted this as well [51]. The important challenge is to expand and sustain these networks beyond the training period.
- Fellowships need to make broader efforts to strengthen research–policy–practice interfaces in LMICs since these are traditionally weak in such settings [37, 38]. Policy translation of research gets limited in the absence of these interfaces.
- Lastly, sustained funding can be a critical bottleneck to the success of such programs. Fellowship programs are cost-intensive, and at the same time, anticipated outputs – such as publications and dashing examples of policy translation – are less visible immediately. The lack of visible outputs can act as a deterrent to sustained funding. Also, more domestic funding needs to be made available and tapped for such fellowships; this will not only enable the sustainability of HPSR capacity building initiatives, but also ensure that the research done aligns with national and sub-national priorities.

We believe that the biggest strength of the India HPSR fellowship program is that it highlights the feasibility of LMIC-led capacity-building initiatives on HPSR. Such

initiatives are particularly lacking in South Asia at scale. Programs such as ours have the potential to inculcate new thinking in participants, help fellows gain practical experience working in HPSR, and open more avenues for career advancements. Furthermore, such capacity-building programs can act as a springboard for developing local and global communities of practice on HPSR. In the long run, such programs can become important channels to challenge the prevailing epistemic injustice in teaching and learning HPSR.

Abbreviations

HPSR	Health Policy and Systems Research
LMIC	Lower- and middle-income countries
HSTP	Health Systems Transformation Platform
HIC	High-income countries
IPH	Institute of Public Health
SCTIMST	Sree Chitra Thirunal Institute of Medical Sciences & Technology
CMC	Christian Medical College
TGI	The George Institute for Global Health
NIGH	Nossal Institute for Global Health
ITM	Institute of Tropical Medicine
BMGF	Bill & Melinda Gates Foundation
C1	Cohort 1
C2	Cohort 2
C3	Cohort 3
CHEPSAA	Consortium for Health Policy and Systems Analysis in Africa
PHFI	Public Health Foundation of India
IR-HSS	Implementation Research for Health Systems Strengthening
HSRII	Health Systems Research India Initiative
IHSC	India Health Systems Collaborative
HPS	Health Policy and Systems
ICMR	Indian Council for Medical Research
NHSRC	National Health Systems Resource Centre
SHSRC	State Health Systems Resource Centre

Supplementary Information

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Additional file 1.

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Author contributions

S.J. and S.R. prepared a preliminary summary analysis and wrote the main manuscript text, which was then shared with all authors. S.M.A., S.K., D.L., P.N.S., D.N., S.V.B., B.M., R.S. and N.D. reviewed the manuscript, deepening and expanding on the conceptual areas in the paper.

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Availability of data and materials

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Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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